CHAPTER ONE
THE EXPERIENCE OF MENTAL ILLNESS
AN INTRODUCTION TO PSYCHIATRIC REHABILITATION

INTRODUCTION
1.What are some of the symptoms and problems that might affect a person stricken with a major mental illness?
2.What is major illness and how is it defined?
3.What is Psychiatric Rehabilitation?
4.When did the practice of Psychiatric Rehabilitation begin?
5.What is the state of Psychiatric Rehabilitation today?

The Chapter is divided into three parts

Major Mental Illness.
What is it
What do we know about it

Psychiatric Rehabilitation also known as Psych/social rehabilitation, is a comprehensive strategy for meeting the needs of people with a severe and persistent psychiatric conditions.

Unlike other illnesses, mental illnesses, do not seem to have predictable courses and outcomes. One person may hear voices and another person might have paranoia. The history of mental illness will differ with people, also.

Each person will respond differently. One person might be severely disabled their whole life and another person might overcome that disability.

MAJOR MENTAL ILLNESSES

About 2.1 to 2.6 percent of the population has a major and disabling mental illness. They are unable to hold a job or keep their living space. That can translate into around six and half million people. Around 2,000,000 people with chronic/long term mental illness are in need of care(Irv Rutman, Matrix Institute)

About 1 percent of the population has schizophrenia. There are also people with depression and anxiety disorders.

There are also people struggling with substance abuse, developmental disorders, learning disorders and/or physical conditions.

THE SYMPTOMS OF MENTAL ILLNESS

Most professionals classify the symptoms of mental illness into two categories

Positive:
Faulty interpretations of reality.
Incorrect sensory perceptions (Hallucinations)
Thoughts (delusions)

Negative:
Social withdrawal
Inability to experience pleasure (anhedonia)

THE CAUSES OF MENTAL ILLNESS

The pathological process which causes mental illness is not very well understood.
Many people feel that there is a strong biological component.
With modern brain scans there seems to be more of biological component.

PSYCHIATRIC DISABILITY

Without effective rehabilitation, mental illness can disable a person.
When people are disrupted in their lives they can not always develop the skills they need to go on in life. Psychiatric Rehabilitation helps adjust a person into living a full life. Psychiatric Rehabilitation can help a person also adjust to the people and environment around them.

Some Psych Rehab theorists and researchers believe that the level of disability is related to their pre morbid(the level before onset of disability) skill level.

Disability is an important medical and social concept

Here is what social security says is disability
1.Activities of daily living (ADL) Grooming, hygiene, maintaining a household, maintaining finances.
2.Social functioning with family, friends and workplace.
3.Concentration, pace and task persistence(ability to function six to eight hours without supervision)
4.The inability to tolerate competitive work
Duration of disability is important factor, also

THE STIGMA OF MENTAL ILLNESS

The stigma of mental illness is big and real. Mental illness often leaves the person identified by their mental illness. A person becomes a schizophrenic and not a person with schizophrenia. Stigma about and against people with mental illness has been around for centuries.

Treating people in the community with mental illness will have the opportunity to also reduce stigma. There are some people who believe that contact with people who have mental illness is the BEST way to reduce stigma. Expensive advertising campaigns do not seem to work.

By living with people in the community, people's humanity will be realized and not their disability.

Keeping people in institutions seems to have added to the centuries of stigma.

PSYCHIATRIC REHABILITATION

Rehabilitation means to restore an optimal state of constructive activity.
Stage of recovery means to cope with person's the illness and disability and also the person's ability to cope.

Many persons with severe and persistent mental illness may be disabled in many or most aspects of their lives.

Ruth Hughes past Director of International Association of Psychiatric Rehabilitation Services wrote:

"The goal of psychiatric rehabilitation is to enable individuals to compensate for, or eliminate the functional deficits, interpersonal barriers and environmental barriers created by the disability, and to restore ability for independent living, socialization and effective life management."

Another definition was:

"Pyschosocial Rehabilitation means that a person who before was afraid to go into a store to order and ice cream soda can now be and ice cream store manager."

THE EMERGENCE OF PSYCHIATRIC REHABILITATION

Practitioners of Psych Rehab are united in believing that persons with severe and persistent mental illness can achieve greater independence and better quality of life through psychiatric rehabilitation services.

Many people for many years thought that mental illness was a downward slide with no recovery.

Today we talk about recovery and Psychiatric Rehabilitation plays a part in many people's recovery.

DEINSTITUTIONALIZATION

Many people in the 1960's and 1970's were unprepared for deinstitutionalization.

Many people who came from the asylum system were seen as not candidates for community mental health care.

Many people who worked and continue to work in mental health were not trained in Psychiatric Rehabilitation. Most undergraduate curricula has focused on more traditional psycho dynamic, cognitive and behavioral therapy, Some therapies even had people relive their experiences which were in the past and did plan for the future.

Also, being institutionalized for many years caused people to learn institutional behavior.

From the perspective of psychiatric rehabilitation, the person should be treated in the community program because it is the less restrictive environment.

PSYCHIATRIC REHABILITATION TERMINOLOGY AND LANGUAGE

The language that we use in Psychiatric Rehabilitation can reflect the attitudes and/or prejudices.

Many of the new labels or personal definitions are consumer, survivor, prosumer, participant and recipient.

The employment of people with psychiatric conditions has brought about the term Prosumer. Many people feel participation by recipients of services shows a more active role in the mental health system, also.

Whatever is used, people first language is always used.

Progressive mental health systems use words which emphasize the persons worth.

People are not defined by diagnosis such as, schizophrenic, paranoid, and/or borderline.

Other words to watch out for- psychos, schizos, the mentally ill, the chronically mentally ill, young chronics, retarded, dual diagnosed.

DEVELOPING PSYCHIATRIC REHABILITATION KNOWLEDGE

In the beginning, many PsyR Practitioners developed these skills by trail and error. Psych Rehab was based on emerging concepts like least restrictive environment, client involvement, and normalization as guidelines.

Over the years, many new and innovative programs were and still are designed, implemented,demonstrated then showcased at the national conference for USPRA. Many new ideas and are still given a chance by implementation and research. These new programs are called emerging programs.

There are also some programs which have an undeniable success and these are called Evidence Based Programs(EBP).

There is an emphasis on Evidence Based Practices these days to demonstrate the effectiveness of PsyR programs.

There also needs to be independent studies to keep away from the Hawthorne Effect. This effect was an experiment which showed improvement not because of better workplace conditions but because people were being studied.

SCIENTIFIC LITERATURE AND MEETINGS

1974 Schizophrenia Bulletin was first published
1977 Psycho Social Rehabilitation Journal was published
Now it is called the Psychiatric Rehabilitation Journal. This is published by Boston University

There are several other journals which regularly carry articles about programs and Psychiatric Rehabilitation.

Psychiatric Services (American Psychiatric Association Journal
Community Mental Health Journal (Journal of National Council of Mental Health Centers)
Journal of Mental Health Administration (Association of Mental Health Administrators)

There are other articles in other journals for more professional services

USPRA is the national organization and sponsors a yearly conference.

WARP is the International Organization and sponsors an international conference every two years.

There is international networking going of to disseminate knowledge and information about Psychiatric Rehabilitation.

CREATING PSYCHIATRIC REHABILITATION PROFESSIONALS

USPRA is the largest organization of Psychiatric Rehabilitation professionals in the United States.

What do Psychiatric Rehabilitation Practitioners do differently than other professionals.

The is a test and the name of Certified Psychiatric Rehabilitation Practitioner (CPRP) behind the person name who can pass the test and comes recommended with the competencies.

SUMMARY

We might be unsure about the cause. We are sure with good intervention and care a person can regain their lives and/or recover their well being. Psychiatric Rehabilitation encompasses both community treatment and rehabilitation. Psychiatric Rehabilitation began in response to deinstitutionalization. Psychiatric Rehabilitation is emerging with its own body of literature and research. USPRA is the major professional organization and working toward professionalization of personnel and services.

CHAPTER TWO
SYMPTOMS AND ETIOLOGY OF SEVERE AND PERSISTENT MENTAL ILLNESS

People with these symptoms can benefit from Psychiatric Rehabilitation Services.
These psychiatric conditions are brain conditions.
People with these conditions seem to be influenced by an interaction between heredity and environment.
(This genetic vulnerability apparently interacts with the environment and developmental factors that provoke the onset of these disorders)

1.What are the most common symptoms of the major mental illnesses?
2.What are the most current scientific theories about the etiology(causes) of these conditions?
3.How does stress affect people who have severe mental illness?

SYMPTOMS

Symptoms are signs or indicators of mental illness.
Symptoms are the causes of suffering for the individual with mental illness.

The symptoms shape how a person thinks about, perceives and reacts to the world around them. In the case of severely and persistent mental illness these symptoms can disrupt the person's entire life.

PERSISTENCE OF SYMPTOMS OVER TIME

People who have persistence of symptoms are sometimes referred to chronic.
This language has fallen out of favor. This definition was very harmful for people.

The question is how do we help people live meaningful, productive lives despite severe difficulties if the symptoms persist?

THE SYMPTOMS OF SCHIZOPHRENIA

The symptoms of schizophrenia are so special that other mental illnesses can be ruled out in this lesson. 65% of people receiving services in our public mental health area are people with schizophrenia.

Drug induced symptoms can bring about a psychosis like schizophrenia but this psychosis is short lived. There are no real physical signs which can measure mental

illness. There are psychological tests which can measure some of the subtle signs of schizophrenia.

POSITIVE AND NEGATIVE SYMPTOMS

Positive symptoms appear to reflect an excess or distortion of normal functions.
Hearing things, seeing things, thinking things. (delusions or paranoia)
When people with schizophrenia hear voices thia is seen as a positive symptom.
Not because it is good, the symptom is positive because it can be clearly defined.

Negative symptoms appear to reflect a diminution of normal functions.
Withdraw, flat affect, lack of goal directed behavior.
Anhedonia means not in pursuit of pleasure.
Avolition lack of will power or ambition.
These negative symptoms are common but many times over looked.
Sometimes people with all mental illnesses seem distracted, mumble to themselves, or seem in their own world. These are negative symptoms.

All aspects of schizophrenia are harmful. People do not like to have the symptoms of schizophrenia or any symptoms of mental illness.

DELUSIONS

Among the common positive symptoms of schizophrenia are delusions. These are bizarre beliefs which a person can not be talked out of. Some people feel that others are in control of their lives or people can read minds. These are two forms of delusions.

Another category of delusion is grandiose delusions, this is thinking that a person has more worth than the person really has. For instance, thinking the person IS the President of the United States.

Other types of delusion might include believing there are evil or negative forces targeting one's self or a loved one.

The impact of delusions on a person can be extreme. Uncontrolled emotional responses such as inappropriate laughter and crying occasionally occur. Delusions may occur by themselves or simultaneously with other major symptoms like hallucinations.

HALLUCINATIONS

Other psychotic symptoms include hallucinations or incorrect sensory information.
Person might think that they have a brain tumor or radio in their brain.
Person might hear things which are not there.

These hallucinations are real. The person really thinks that they are there!

Sometimes the voices keep a running commentary on the person's actions or thoughts. Sometimes there are multiple voices converging on each other.

Voices speaking one's thoughts aloud are another example. One man said "I have very loud thoughts"
Two or more voices arguing another example.
Voices commenting on one's action a third example. Thinking that other people are talking who are not.
Voice or voices telling a person to do something that is specific is the last example. These are called command hallucinations.

THOUGHT DISORDERS

These disorders are where cognition or thinking is disordered. People can think they are broadcasting thoughts or others are broadcasting thoughts to them. Also, racing thoughts or thinking that they are inserting or having thoughts inserted in them is another sign of schizophrenia.

THE EXPERIENCE OF SYMPTOMS

Sometimes it is hard to tell which symptoms the person is experiencing.
Sometimes people act on hallucinations or symptoms and also commit bizarre acts.

Although behavior can seem bizarre people can be in touch and aware and get through hallucinations and/or delusions with out causing harm to anyone.

Sometimes people learn to live with these symptoms and function with difficulty-however they DO function.

PHASES OF SCHIZOPHRENIA

Prodromal Phase-this is the phase before the onset. There can be signs that the person is starting to experience something.

Acute or Active Phase-This is period of the most active symptoms. For instance this might be hearing voices, increased suspicion or withdrawal.

Residual Phase-This is where both negative and positive symptoms decrease. Negative symptoms seem to stay active after the positive symptoms decrease.

HOW THE PHASES OF SCHIZOPHRENIA AFFECT CONSUMER'S LIVES

Many people face these phases of schizophrenia repeatedly.
They live with persistent negative symptoms. There can be also or simultaneously bursts of positive symptoms.

Functional deficits interfere with goal directed behavior involving one's career and lifestyle.

A disproportionate amount of people are unemployed for long periods of time, have not finished their education, do not reside in their own homes, are unmarried and also can be estranged from their families.

These are areas where the Psychiatric Rehabilitation Practitioner might be of great help. Education-Housing-Relationships-Family support and unification.

MOOD DISORDERS

More common than schizophrenia are mood disorders. They affect from 5% to 20% of the American population. People with mood disorders only make up about 25% of the service delivery in public mental health.

The most serious mood disorders are episodic, recurrent, and cause significant functional deficits.

Depressive Episodes are characterized by extreme sadness or emptiness lasting most of the day, every day for two or three weeks or longer.

Manic Episodes are marked by elevated moods where a person is up or high and excessively irritable for a week or more.

ARE SCHIZOPHRENIA AND MOOD DISORDERS DIFFERENT?

One deals with psychotic symptoms and the other deals with mood variances.
Yet, there can be overlap.
People with schizophrenia can have mood swings.
People with mood swings can have delusions and hallucinations.

The symptoms of mood disorders and schizophrenia can resemble each other and in some case can be identical.

Individuals who have schizophrenic symptoms and meet the criteria for mood disorders are given the diagnosis of schizoaffective disorder.

RELEVANCE TO PSYCHIATRIC REHABILITATION

This past information has been to help show the disruptive nature of mental illness. These symptoms are more serious than the up and downs of everyday life.

Professionals who have knowledge of symptoms can help people live and monitor and cope with their conditions.

Most PsyR interventions do not focus on the symptoms. Psych rehab focuses on the impairments which the symptoms might cause. To get past the impairments the Psychiatric Rehabilitation Practitioner focuses on the strengths of what the person has to offer.

Unfortunately, many professionals focus on the symptoms and overlook what the person might be able to accomplish. How can we get people out of their impairments like withdrawal, hearing voices, depression and other characteristics of the psychiatric condition?

What are we learning:
1.To not dwell on crisis or symptoms or bizarre behavior.
2.Do not overlook the strengths and and personal interests.
3.Try to see the people who we are working with as just in the struggle of life, with some very magnified difficulties.

That is the challenge of the Psychiatric Rehabilitation Practitioner to help get people out of impairment and/or disability.

DUAL DIAGNOSIS

The term dual diagnosis refers to presence of two coexisting conditions.
The two condition most encountered are mental illness and substance abuse.
This can also refer to mental illness and developmental disability.

MENTAL ILLNESS AND DEVELOPMENTAL DISABILITY

Developmental Disability is a condition which arises in child hood and causes serious problems in language, learning, mobility and the capacity for independent living. The person's brain does not develop in a timely way like the others around. Their ability to think, learn, and act has become delayed.

Since the mid 1800's most people with developmental disability had been institutionalized most of their lives.

In the 1950's parents of people with development disabilities rejected the idea of institutions and sought to have their children educated and developed through others services than institutions.

Again, people with developmental disabilities, were moved into environments of least restrictive care.

Many people, such as, Wolfenberger, who articulated the principles of normalization and Marc Gold, who demonstrated that people with the most severe cognitive difficulties could learn complex skills.

Many people today with Developmental Disabilities are able to live, learn and work in the community.

INCIDENCE OF DEVELOPMENTAL DISABILITY

Studies suggest that about 20% of people with Developmental Disabilities living in the community also experience mental illness. The incidence of schizophrenia seems to be as high as the public number which is about one per cent.

Diagnosing and understanding which is the mental illness AND which is the Developmental Disability can be difficult. Misdiagnosis can happen.

MENTAL ILLNESS AND SUBSTANCE ABUSE

The dual diagnosis of mental illness and substance abuse refers to the presence of severe psychiatric disorder and substance abuse.

People with mental illness are now in the community and exposed to drugs and liquor.
Some people have used drugs and liquor before mental illness.
Some people might have induced their onset of mental illness from drugs and liquor.
Some people might be self medicating with drugs and liquor.

The mixture of mental illness and substance abuse has a profound impact on medical needs, employment, legal involvement and family/social problems.

ETIOLOGY

What are the origins of the strange symptoms?
Why do some people get major symptoms?
What is the source of major mental illnesses?

PHYSIOLOGICAL EVIDENCE OF THE DISEASE PROCESS IN THE BRAIN

The evidence is overwhelming that mental illnesses are changes in the functioning and structure of the brain.

Ventricles in the brain are large fluid enclosures.
Sulci are the spaces in the brain.

People with mental illness seem to have less brain tissue and more spaces in the brain than people who do not have mental illness.

A variety of studies have shown that people with schizophrenia have under active frontal lobes. This means that a person is likely to have lack of energy, poor attention and concentration, poor emotional control, flat affect and restlessness. These problems correspond to the negative symptoms of schizophrenia.

NEUROTRANSMITTERS

All behavior and activity is based on the neurotransmitters of the brain.

Dopamine and neurons that use dopamine are involved in all sorts of behavior, especially, movement, hearing and perhaps planning.

Norepinephrine Also know as Adrenalin, is involved with the circulatory system, the heart, but also affects sleep, appetite, and sexual behavior.
Serotonin This neurotransmitter also affects sleep, impulse control and other functions
Acetylcholine This neurotransmitter affects movement and muscles.

NEUROTRANSMITTERS AND MENTAL ILLNESS

Two neurotransmitters seem to be directly involved in schizophrenia
Dopamine and serotonin.

Brain development is influenced directly by psychosocial and physical factors.
A person who has a genetic vulnerability combined with a chain of biological or environmental stressor might experience an onset of mental illness.

This could be a response to an environmental insult or stressor.

THE ROLE OF GENETIC FACTORS

One's possibility of having mental illness is increased if the blood relatives have this condition. Studies have found that even if you never had any contact with the blood relative and never shared the same environment-a person has a good chance of developing schizophrenia.

THE ROLE OF GENETIC FACTORS

What causes these changes neuroanatomy and neurotransmitter functioning?
Science suggest to a large extent that these conditions are inherited.

RISK AMONG BIOLOGICAL RELATIVES
The risk increases significantly if one of the parents or one of siblings has mental illness.

Apparently, genetic heritage plays an important role in these diseases.

In one study of twins almost all children who had a biological parent with mental illness went on the develop that mental illness(Schizophrenia in this study)also

THE ROLE OF STRESS

Major mental illness is not caused by the daily stresses of life. Stress may play a part in in onset due to genetic factors. The most obvious example is the loss of a loved one. Normal people experience a loss for several weeks but people with depression can have an onset of an episode which disrupts their normal functioning in both intensity and length of time.

Stressful life events also play a role in the onset of people Bipolar disorder.

The influence of stress does not seem to play a role after the onset of mental illness.

THE STRESS-VULNERABILITY-COPING-COMPETENCE MODEL

Individuals can inherit major mental illness and these illnesses can also be brought about by stress or inability to cope with stress(which might also be biological).

Stressors which have the ability to bring on acute episodes are personal losses, developmental transitions, and stressful life events such as marriage, graduation and moving. Physical illness, injury, substance abuse and physiological factors such as sleep deprivation can also bring on mental illness.

The factors which can prevent the onset of mental illness are coping skills, supportive resources and competence in relevant life activities.

The role of psychiatric rehabilitation is to aid and develop some coping skills.
Severity of the symptoms can have a lot to do whether the coping skills are in place.

THE MYTH OF “THE MYTH OF MENTAL ILLNESS”
Thomas Szasz thought that mental illness was artifact or creation of psychiatry.
Yet, the profound symptoms and functional deficits which people experience are real.

R.D. Laing felt that psychosis is a healing process. Through psychosis the person regresses to the developmental stage at the core of their problem. He built centers

where people could live in psychosis. He was not only NOT helpful, he might have been harmful. The brain becomes atrophied if not treated.

Loren Mosher felt that people should not be treated because it deprives the people of their experience. He felt that they would become out of touch with themselves.

SUMMARY

People who are served in psych rehab programs have a variety of diagnoses. The most common psychiatric condition in our mental health programs is schizophrenia. These disorders are long term often have acute phases followed by long term residual phases. In the acute phase and other times also, there are serious behavioral manifestations which preoccupy the sensory and cognitive experience of the individual.

Most people receiving psych rehab services have experienced psychotic symptoms, such as hallucinations, delusions, and thought disorders which are disruptive.

Brian scans have shown that psychiatric conditions are biological.

Twin studies and other studies have show that vulnerability to mental illness is inherited genetically.

This combination of biological influences, environmental factors and psych social stressors contribute to further harm. These symptoms have severe cognitive(thinking) psychological and social consequences for the individual.

CHAPTER THREE
COURSE, OUTCOME, AND TREATMENT OF SEVERE AND PERSISTENT MENTAL ILLNESSES

INTRODUCTION
Understanding the course, outcome, treatment of mental illness

The COURSE of an illness is its natural history-the sequence of events through the illness.
Outcomes can refer to specific results and/or the end of specific treatment.

Treatment is defined as the action designed to cure a disease.
Treatment is to alter the course of the disease or reduce the frequency of relapse

The course or natural history of mental illness is uncertain.

There is risk of relapse within even periods of remission.

There are also health factors
Bi Polar disorder can reduce life span by nine years

People with schizophrenia in one study:
67% had relapse
11 % of everyone did not recover
10% of all people did commit suicide.
However-
21% had negative outcomes
80% did experience some significant form of recovery

COURSE

SHORT-TERM COURSE OF THESE DISEASES
The course of mental illness in the first phase is difficult. The time before receiving treatment can be devastating and frightening.

Diagnosis can change after treatment.

Many people are diagnosed with these diseases in the teens or early twenties.
Many people might have denial. This can be life affirming and can also lead to non compliance with medication and relapse.

For many people the first treatment experience is with hospitalization.

With the medication, comes other side effects-which can make the condition worse.

RECIDIVISM will be very high within the first one to five years. This rate increases in time so that a person hospitalized within their lives has a good chance of returning to the hospital once if not more.

LONG-TERM COURSE OF THESE DISORDERS
Until recently, the long term prognosis for a person with severe mental illness was considered bleak. Many people thought the diagnosis was downward over time.

E. Fuller Torrey breaks out the outcomes into five categories

Completely recovered
Much improved
Improved
Hospitalized
Dead

10 years after discharge

Completely recovered 25%
Much improved 25%
Improved 25%
Hospitalized 15%
Dead 10% (mostly suicide)

30 years after discharge

Completely recovered 25%
Much improved 35%
Improved 15%
Hospitalized 10%
Dead 15% (mostly suicide)

COURSE OF MOOD DISORDERS
There is some evidence which suggests that course of chronic mood disorders may worsen over time.

Recurrent episodes has lead to deterioration over time.
The number and frequency of mood disorder frequency can increase over time.

The natural course of both uni polar and bi polar seems to get worse over time.

Full medication compliance seems to reduce symptoms but not reduce them.

DO REHABILITATION SERVICES MATTER?

Both, in Vermont and Maine studies, people who were released from the psychiatric hospital received better services. People in Vermont improved faster probably because their services were more psychiatric rehab in orientation.

This is also show in other research around the world. Hopefulness-one of the basic values for psychiatric rehabilitation is shown effective.

TREATMENT

Categories of treatment are both biological(somatic) and psyhcosocial

BIOLOGICAL

EFFICACY OF ANTIPSYCHOTIC MEDICATION

Studies show that 65% to 85% percent of people improve dramatically when they use medication.
Medications at different levels are used in acute, residual and prodromal courses of mental illnesses.

COURSE OF SCHIZOPHRENIA WHEN TREATED WITH ANTI PSYCHOTIC MEDICATION

A study (1993) found that relapse was reduced from 67% to 39% in the first year with medication compliance. And, with the second year, with medication compliance was reduced from 65% to 15% annually.
There is still a significant amount of medication non compliance because of poor response.

Here are some other reasons

-Physical intolerance of medication resulting in serious side effects, bodily adaptions that make the medication ineffective.
-Partial compliance of person with treatment regimen
-Inappropriate dosing or length of trail(most medications require 4 to 6 weeks to determine efficacy)
-True resistance of the disorder to the medication.

PHARMACOLOGICAL TREATMENT OF BI POLAR DISORDER AND MANIA
Many studies show that Lithium works with people who have Bi Polar conditions.
Valproate is preferred in acute episodes.

Antipsychotics are also powerful anti maniacs.

Course of Bi Polar Disorder When Taking Lithium
Lithium does not seem to consistently reduce the recurrence of manic episode in regular practice. Yet, people taking Lithium in one study had better outcomes than those not taking Lithium.

MAJOR DEPRESSIVE DISORDERS
There is a controversy about whether medications or psychosocial interventions work best.

The medicinal treatment of choice for people with depression are medications known as serotonin re uptake inhibitors.
Next, tricyclic anti depressants.
Finally, There are MAO inhibitors.

Again, the benefits of taking medication for depression and the risks of stopping medication are well known. Even gradual discontinuation did not yield lower relapse rates. Even when medication is taken there are periods of relapse.

REASONS MEDICATIONS FAIL
Medications must be tried for a specific length of time. The need for accurate evaluation will continue for a period of time.

Questions could be
Which psychotropic medications could be the most effective?
Which dose is needed to not put the person at risk for side effects?
How does one cope with long term needs to take medication and possible test for a long time?

MEDICATION SIDE EFFECTS
There can be increased appetite, hormonal difficulties(failing to have menstrual cycle), motor difficulties(shuffling gate), muscular problems(stiffness), dryness of mouth, blurred vision, impotence, low blood pressure, seizures and immune system reactions.

Tardive dyskinesia is uncontrollable mouth and body movements.

What is the role of the Psych Rehab Practitioner?

Coercion to take medication is not part of the practice. Goals need to be client chosen. If the person choses not to take medication, the Psych Rehab Practitioner can educate but not dictate. Try to teach the person living skills is the job of PsyR practitioner.

Still-these are ethical questions about taking medicaiton and there are no easy answers.

It is important the Psych Rehab be thoughtful to consider ethical implications and to have an open dialog when struggling with consumers and professionals.

PSYCHOSOCIAL TREATMENTS
Many people believe that the best outcomes are from a mix of pharmacological treatments and psych social treatment.

Psycho social treatments are not psycho therapies. Some people believe that psycho social interventions can be effective regardless of a person taking or not taking medication.

SOME INEFFECTIVE TREATMENTS
Insight oriented, psychodynamic therapies can be defined as those that use interpretation of unconscious material and focus on therapeutic transference.

Some studies have found psychodynamic treatments to be either in effective or harmful.

Therapeutic settings which seem positive might be harmful if they are high in intensity or expectations.

EFFECTIVE PSYCHO SOCIAL TREATMENTS

The book, Psychiatric Rehabilitation by Ken Gill, Carlos Pratt, Melissa Roberts and Nora Barrett shows the treatment interventions which work as psycho social rehabilitation.

Day programs, assertive community treatment teams, vocational rehabilitation, residential and family approaches will be taken from the book and outlined in this synopsis.

PSYCHO SOCIAL TREATMENT OF MOOD DISORDERS
The most promising practice for people with mood disorders is the psychoeducational approach. Psychoeducation focuses on illness information, treatment compliance and illness management. There is a direction toward wellness. This treatment is also good for people with schizophrenia. Education is a valuable tool for teaching and maintaining wellness.

PSYCHO SOCIAL TREATMENT OF MAJOR DEPRESSION
In the treatment of depression behavioral therapy, cognitive behavioral therapy, marital therapy and interpersonal therapy all have been found to reduce depressive symptoms.

WHAT WE SHOULD KNOW BAOUT THE COURSE, OUTCOME AND TREATMENT OF SEVERE AND PERSISTENT MENTAL ILLNESS.
Although schizophrenia and mood disorders often differ markedly in their symptomatology, the medications used to treat them, and to some degree their course, there are some shared elements.

These symptoms can dominate the person's experience at times, to a large extent controlling the person's thoughts and feelings, These symptoms can be harmful to the person's self esteem and hopefulness and put the person at risk for suicide.

Psychiatric Rehabilitation Practitioners are trying to assist in improving self-care, employment, home making, educational achievements, and independent living.

There is no uniform outcomes. There can be general progressions of improvement.

Everyone is treated with powerful psychiatric medications. And from those medications, there can be physical side effects which can impair full progress to psycho social assistance.

Counseling can be useful but there is a real need for all people with severe psychiatric disabilities to have psycho social rehabilitation interventions.

Several areas which seems to be effective through research are skills training, supported employment, family interventions and integrated treatment for people with Co Occurring Disorders.

SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES AND MENTAL ILLNESS
Comprehensive community programs is important for these services.
All learning should take place in real life situations.

Functional, individualized approach Training focuses on the individual in a specific environment and develops the skills needed by the individual to be successful there.

Training-rather than testing-means observing the person in the environment. This helps to assess the person's skills and deficits and informs the training process. Testing merely provides a description of the person's performance AT THE MOMENT on tasks designed for people with greater cognitive disabilities.

Unconditional positive regard- The individual is given the respect, concern, courtesy, attention and affection that would be afforded to any human being. It also means that the person is not blamed for his or her disability or resulting lack of experience or skills.

Behavioral communication- Behavior is a means of communication. This is particularly true for people with little or no experience with language. Behavior therefore is viewed as such and rather than being punished is used to understand the person and inform services.

Ecological behaviorism- Behavior is seen as a complex interrelated system that is influenced by the environment rather than a simple example of stimulus response.

A balanced approach is necessary. Both psychotropic medication and behavioral programming are useful tools to help the individual achieve independence.

SERVICES FOR PERSONS WITH SUBSTANCE ABUSE DISORDERS AND MENTAL ILLNESS.

The services for people with Co Occurring Disorders is important because people who have these conditions seem to require extensive service and support needs.

There have been found to have a high rate of emergency services, low rate of responsiveness to services and greater risk for suicide and violence.

Mental health and substance abuse services often operate out of different bureaucracies and funding streams.

Substance abuse tends to be more confrontational, expecting the individual to take responsibility for his or her sobriety and for asking for services. Mental health tends to employee more outreach, case management, and support in engaging the person in services. Mental health services also are more tolerant of a gradual approach to abstinence and that includes providing services who are still using substances.

Both services employee a bio psycho social model of recovery. Both services work to assist the person to accept the illness, develop skills and supports needed to succeed in all areas of life, and prevent relapse.

The three models

Sequential service model The consumer receives non simultaneous services from both mental health and substance abuse systems.

Parallel service model The individual receives both substance abuse services and mental health services at the same time from each respective system

Integrated service model Combines substance abuse services and mental health services into the same system by either cross training professionals in the same area or using integrated treatment teams.

SELF HELP AND RECOVERY FROM SUBSTANCE ABUSE AND MENTAL ILLNESS

Substance abuse programs place a strong emphasis on self help. These self help meetings are usually based on the 12 step model. Some times people in these programs are opposed to all mood altering medications. Medications are seen as drugs. There are modified support meetings now based on the Double Trouble model. This is both mental illness and substance abuse.

Regardless of which model, the recovery from substance abuse addresses four areas:

Physical is eliminating the substances from the body and eliminating the cravings. Detoxification and restoring health are also part of this. Eliminating cravings is also important.

Psychological is overcoming denial and establishing abstinence. Identifying emotional stability, identifying personal strengths and weaknesses, examining the impact that one's addictions had on others, developing substance free environment, and developing a plan for relapse free life and long term recovery are part of the psychological aspects.

Social means making amends for the problem and other parts of the addictions that have taken a toll on people. Also, this included developing a support network and alternative leisure activity. Dealing with problems caused by the addiction this includes possible legal and housing problems.

Spiritual means developing a belief in power greater than one's self. Also, this means putting meaning and positive values back into a person's life. This also means helping others who are in recovery or addicted.

Both recovery from substance abuse and mental illness are based on not having a cure.

UNDERSTANDING COURSE, OUTCOME, AND TREATMENT: WHAT STAFF AND CONSUMERS DON'T KNOW CAN HURT THEM

Continuing on a maintenance dose of medication seems to help people with psychiatric conditions stay stable. Discontinuing medication can cause relapse. Conveying the knowledge and importance of continuing to take medication is important

Yet, what is also imperative for psychiatric rehabilitation practitioners is understanding the course and outcome of severe and persistent mental illness.

Practitioners who are unaware about relapse might not understand that relapse can be an outcome. Might also set too high or too low goals.

A realistic understanding of the limited efficacy of treatment, the stormy course of the illness, and the variety of potential outcomes is more likely to result in high quality services and better rehabilitation outcomes.

For instance, many staff and consumers might not understand the course of the illness. When the course of rehabilitation does not go as planned, many people are frustrated and feel bad.

For the person in recovery, not succeeding might result in hiding, denying symptoms or dropping out of treatment because the person feels so disenchanted.

There can be frustration with feeling not successful and this leads to BURNOUT.

Periodic relapse is seen as a function of the illness and not a failure. People in the programs and people who work in the programs might both feel disenchanted.

Low expectation can lead to false sense of helplessness. Can also lead to staff not caring or putting in enough time to work with people. There needs to be continual positive and expectations for staff.

Believing in positive outcomes, often results in positive outcomes.

SUMMARY

The course of severe and persistent mental illness is lengthy.

The outcome is never full recovery and yet there are a variety of outcomes.

There are also a multiplicity of outcomes. Psychiatric Rehabilitation Practitioners need to be experienced and prepared to work with the this variety of outcomes.

To avoid burnout and pessimism on the part of the staff and alienation and helplessness on the part of people who receive services, all stakeholders should be informed in order to develop appropriate and realistic expectations.

CHAPTER FOUR
GOALS, VALUES AND GUIDING PRINCIPLES OF PSYCHIATRIC REHABILITATION

INTRODUCTION
Psychiatric Rehabilitation is a young field and continuously re defining itself

1.How does the concept of recovery inform the goals, values and philosophy of psychiatric rehabilitation?
2.What are the goals of psychiatric rehabilitation?
3.What are the definitive values held by psychiatric rehabilitation professionals?
4.What are the guiding principles that inform state-of-the-art PsyR practice today?
5.What are the ethics of PsyR?

THE CONCEPTS OF RECOVERY
Many of the ideas and values of psychiatric rehabilitation came from working with people who have physical disabilities. People with physical disabilities are much accepted today than they were ten years ago. The public can relate more to people with physical disabilities than people with psychiatric disabilities.

The concept of recovery is one of the most interesting developments in psychiatric rehabilitation training.
These are the concepts which Bill Anthony laid out around 1993.

Recovery: Definition & Components
Since the mid-1980s, a great deal has been written about mental health recovery from the perspective of the consumer (client), family member and mental health professional.

The amount of research of various aspects of recovery continues to grow. Early research by Courtney Harding (1987) and others challenged the belief that severe mental illness is chronic and that stability is the best one could hope for.

They discovered there are multiple outcomes associated with severe mental illness and that many people did progress beyond a state of mere stability. As such, the concept of recovery began to obtain legitimacy (Sullivan,1997).

Although there are many perceptions and definitions of recovery, William Anthony, Director of the Boston Center for Psychiatric Rehabilitation seems to have developed the cornerstone definition of mental health recovery. Anthony (1993) identifies recovery as " a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles.

It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

Ultimately, because recovery is a personal and unique process, everyone with a psychiatric illness develops his or her own definition of recovery. However, certain concepts or factors are common to recovery. Some of these are listed below.

Hope

Hope is a desire accompanied by confident expectation. Having a sense of hope is the foundation for ongoing recovery from mental illness. Even the smallest belief that we can get better, as others have, can fuel the recovery process.

Early in the recovery process, it is possible for a treatment provider, friend, and/or family member to carry hope for a consumer. At some point, however, consumers must develop and internalize their own sense of hope.

Medication/Treatment

While many people are frustrated by the process of finding the right medications and the side effects of medications, most persons with a psychiatric disorder indicate that medications are critical to their success (Sullivan, 1997). For many, the goal is not to be medication-free, but to take the least amount necessary.

Likewise, mental health consumers often report that mental health professionals and treatment programs are valuable to their recovery. Especially when consumers feel they are engaged in a partnership with their treatment provider and are involved in their treatment planning.

Empowerment

Empowerment is the belief that one has power and control in their life, including their illness. Empowerment also involves taking responsibility for self and advocating for self and others. As consumers grow in their recovery journeys, they gain a greater sense of empowerment in their lives.

Support

Support from peers, family, friends and mental health professionals is essential to recovery from mental illness. It is especially beneficial to have multiple sources of support. This not only reduces a consumer's sense of isolation, but also increases their activity in the community, allowing them to obtain an integral role in society.

In addition to support from individuals, participation in support groups is an important tool for recovery. Consumers frequently report that being able to interact with others who understand their feelings and experiences is the most important ingredient for their recovery.

Education/Knowledge

In order to maximize recovery, it is important to learn as much as possible about our illnesses, medications, best treatment practices and available resources. It's also important to learn about ourselves, including our symptoms so that we can gain better control over our illnesses.

Consumers can educate themselves by speaking with health care professionals, attending workshops and support groups, reading books, articles and newsletters, browsing the internet and participating in discussion groups.

Self-help

While most consumers recognize the value of professional treatment, self-help is often viewed as the conduit to growth in recovery. Self-help can take many forms including learning to identify symptoms and take actions to counteract them, reading and learning about an illness and its treatment, learning and applying coping skills, attending support groups and developing a support system to rely on when necessary.

Spirituality

A broad definition of spirituality is that it's a partnership with one's higher power. For many consumers spirituality provides hope, solace during their illness, peace and understanding and a source of social support.

Employment/Meaningful Activity

Frequently, when we meet new people, they ask "what do you do?" Whether it is fair or not, what we do shapes others' opinions of who we are. As a result, it is common for a person's identity to be significantly impacted by what they do. Likewise, what a person does influences his/her confidence, esteem, social role, values, etc. Simply put, employment/meaningful activity affords most consumers the opportunity to regain a positive identity, including a sense of purpose and value.

Both Bill Anthony and Patricia Deegan have spent a lot of time spreading the ideas of Recovery through out the mental health and psychiatric rehabilitation community.

The self concept has to change so that a person sees themselves differently. A person with hope. A person who can accomplish goals.

Each person road to recovery is different. There are many roads to recovery. Some people might not see what they do or have accomplished as recovery.

Because the core task that the recovering individual has to accomplish is the development of a new and positive self image other people in recovery around that person are important.

The role modeling concept is fundamental that it is forgotten in some cases. The staff are also role models. Everyone is trying to exhibit the behavior that they would want to receive. Everyone is being treated the way that they would want to be treated.

Progress is seen in several different areas.

1. Results of landmark studies on the real outcome of schizophrenia
2. Recent introduction of improved medication
3. Encouraging outcomes from new development in psych rehab. Supported Employment is an example. Ten years ago people still believed in keeping people in day programs. Today Supported Employment is valued.
4. Debunking myths of mental illness.

The concepts of Recovery embodies both optimism and hope.

GOALS, VALUES AND GUIDING PRINCIPLES
Goals represent desired states or objectives to strive for and achieve.
Principles are the guidelines or values that deliver services

THE GOALS OF PSYCHIATRIC REHABILITATION
1.Psych Rehab services are designed to a person with mental illness recover
The important point here is that each person must define their own recover and path to recover. We only help help or assist. We do not define or push.

2.Psych Rehab services are designed to help persons with mental illness achieve maximum community integration.
The person must be able to live in the community with a variety of ways which lead to more independence that the person defines. This would be the less restrictive environment which the person defines.

3.Psych Rehab services are designed to help persons with mental illness highest possible quality of life. Each person should have the opportunity to live with the highest quality of life that is defined by them. Through modeling each person in our programs may come to change their definition on what is quality of life

THE VALUES OF PSYCHIATRIC REHABILITATION

-Psych Rehab believes that everyone has the right to self determination, including participation in all decisions which affect their lives
This value is referred to as empowerment

One important part of empowerment is education and knowledge about the person's condition. Researchers found out that people who accepted their mental illness had higher levels of functioning.

Some consumers in day programs were given the chance to share power, and economic resources with consumers. Consumers improved their participation in programs and had improved outcomes.

-Psych Rehab believes in the dignity and worth of every human being, regardless of degree of impairment or disability.
People are in now way lessened by their mental illness. Everyone has worth or dignity.

-Psych Rehab Practitioner is optimistic regarding the improvement and eventual recovery of persons with severe mental illness who are provided services
Everyone has the opportunity to benefit from services. Providers of services who do not have optimism might fail to deliver services for optimal success.

-Psych Rehab assumes that everyone has the capacity to learn and grow
Having mental illness does not preclude anyone from learning and growing.
Our time with people can be educational for both us and them.
Everyone can learn and grow

-Psych Rehab practitioner is sensitive to the individual, cultural and ethnic differences for each consumer(person).
Mental illness knows no cultural or ethnic boundaries. When we try to reintegrate people back into the community we need to be aware of the cultural and ethnic backgrounds they came from.

GUIDING PRINCIPLES OF PSYCHIATRIC REHABILITATION

INDIVIDUALIZATION OF ALL SERVICES
Individualized services needs are personal to the person needing them.
For instance, if a person is ready for job placement they can be placed. A person doesn't have to go to endless training and counseling to get a job.

MAXIMUM CLIENT INVOLVEMENT, PREFERENCE, AND CHOICE
This principle is based on personal nature of recovery and rehabilitation
Participation is new importance of all that being done in the new mental health services

NORMALIZED AND COMMUNITY BASED SERVICES
People are supposed to have valued social roles. People are spoken to as adults. People live in decent neighborhoods, and there needs to not be institutionalized thinking.

STRENGTHS FOCUS
Pscyh Rehab Practitioners build on an individual's strengths. Not what is work with the person. Deficits analysis has been part of the benefits application process.

SITUATIONAL ASSESSMENTS
This means that the overall assessments focus on the skills and modifications necessary for the person to succeed. Some people might need improvement in interpersonal skills and some people might need a change in the ability to operate a cash registrar or change in work schedule.

TREATMENT/REHABILITATION, INTEGRATION, HOLISTIC APPROACH
Treatment refers to symptom relief.

Rehabilitation refers to overcoming barriers and pursuit of goals
These two are done together in psychiatric rehabilitation
Psycho education is used to help improve understanding of symptoms, side effects and the psychiatric condition. Education is strong component of psych rehab.

ONGOING ACCESSIBLE, COORDINATED SERVICES
These services should be unlimited in respect to time. There are many changing needs of the person and these needs need to be tailored as needed or wanted with the person receiving services.

Coordination of services is an important part of psych rehab. Lack of service coordination can be harmful.

VOCATIONAL FOCUS
Work is an important part of all psych rehab practice. People are not only encouraged to work but they are also shown how to work. Find the person's strengths and work to have accomplishment. This is not about power-this is trying to get some things done.

SKILLS TRAINING
These are not just skills that people need on the job. These are skills that people need to negotiate in every day life. This requires sharing and sense of mutuality so that all people can learn.

ENVIRONMENTAL MODIFICATIONS AND SUPPORTS
This does not always require understanding of physical planning. There is a need to understand time changes, like building in time to get away. Time for therapy. Time for a phone call for support, etc.

PARTNERSHIP WITH THE FAMILY
The best family education requires the family to also be involved. Families also with consumers with be there as part of governing boards, also

EVALUATIVE, ASSESSMENT, OUTCOME ORIENTED FOCUS
To insure the best outcome, providers must always be assessing and evaluating their programs. Good programs also have full participation of the mental health consumers participation in all aspects of program design and implementation.

CORE PRINCIPLES OF PSYCHIATRIC REHABILITATION
1. The ultimate goal is recovery
2. All people have the capacity to learn and grow
3. People have the right to direct their own affairs, including the services that they receive, related to their psychiatric disability.
4. All people are to be treated with respect, dignity, and with a conscious and consistent effort to eliminate labeling or discrimination of any type, including discrimination based on disabling conditions.
5. Psych Rehab Practitioners recognize and appreciate culture and ethnicity as a source of strength and enrichment to person and services in recovery.
6. Psych Rehab builds on the strengths of each person to help in recovery and integration into the community
7. Services are to be integrated, coordinated, accessible and available as long as needed.
8. All services are to be designed address the unique needs of each individual. This includes cultural values and norms.
9. Services are normalized, community centered and encompass the whole life of the person.
10. Psych Rehab practitioner involves the person in normal community activities, such as school and work, throughout the rehabilitation process.
11. The partnership and involvement of people receiving services and family members are essential to the effective operation, evaluation and governance of Psych Rehab services.
12. Psych Rehab services should continually strive to improve the services which they provide.

Self Determination vs Quality of LIfe
How much better is a person in an impatient unit and on the streets?
Where do the rights of those receiving the services begin and leave off?
With limited public funds what is a quality of life?

PSYCHIATRIC REHABILITATION ETHICS

Conduct and Comportment

A. Practitioners maintain high standards of personal conduct in their capacity or identity as Psych Rehab Practitioner.

B. Practitioners strive to be proficient in Psychiatric Rehabilitation and in the performance of service delivery.

C. Practitioners regard as primary the obligation to help individuals achieve their needs and wants.

D. Practitioners promote multi-cultural competencies in all places and relationships in the practice of psychiatric rehabilitation..

Ethical Responsibility to People Receiving Services

A. Primary responsibility of Practitioners is to persons receiving Psychiatric Rehabilitation Services.

B. Practitioners refrain from entering into dual relationships

C. Practitioners act with integrity with colleagues, families, significant others, other organizations, agencies, institutions, referral sources and other professionals.

D. Practitioners make every effort to support the maximum self determination of the person served.

E. Practitioners respect the privacy of consumers and in confidence all information obtained.

Ethical Responsibilities to Colleagues

A. Practitioners treat colleagues with respect, courtesy, fairness and good faith

Ethical Responsibilities to the Profession

A. Practitioners uphold and advance the mission, ethics and Principles of Psychiatric Rehabilitation.

B. Practitioners assist the profession by promoting Psychiatric Rehabilitation Services as primary modality

C. Practitioners take responsibility for identifying, developing and fully utilizing knowledge in professional practice.

Ethical Responsibility to society

A. Psychiatric Promote General Welfare of Society by promoting the acceptance of persons with mental illness.

RESEARCHING PRINCIPLES OF PSYCHIATRIC REHABILITATION

There has been ongoing research about Psych Rehab.

Psychiatric Rehabilitation Journal is probably the most well known publication in this field.

People should be familiar with this Journal to be at least up to date on the contents.

Psych Rehab is an evolving field.

Know the Guiding Principles of Psych Rehab and become a good practitioner.

THE FUTURE OF PSYR THOUGHT AND PRACTICE

Psych Rehab is again continually evolving and growing and changing.

SUMMARY

Psychiatric Rehabilitation shares many similarities with physical rehabilitation.
The most important part is that Psych Rehab has developed the concept of recovery.
The primary goals of Psych Rehab are to achieve recovery, maximum community integration, and the highest possible quality of life.
These goals are supported by values including self-determination, respect for human dignity, optimism and the belief that all people have the capacity for growth.

CHAPTER FIVE
PSYCHIATRIC REHABILITATION METHODS

1. What elements make up a successful psychiatric rehabilitation intervention?
2. What is the role of the professional in the rehabilitation process?
3. What is the role of the consumer in the rehabilitation process?
4. Can consumers learn skills and can they apply the skills they have learned?
5. What role do environmental supports and modifications play in the rehabilitation process?

INTRODUCTION
The Center for Psychiatric Rehabilitation at Boston University has been at the center for psychiatric rehabilitation for some time. The Center both trains people on and off the site. The center brought a successful rehabilitation process through the concept of readiness. Using the assessment information the Center teaches not only the consumer's readiness, but also his or her skill use, and the environments in which people need to work. Strategies to define each goal or objective are defined. The Center characterizes these steps as the diagnostic phase, planning phase, and the interventional phase.

CONSUMER CHOICE
Consumer choice in each and every aspect of the process is a basic ingredient of any successful rehabilitation. Consumer involvement also demonstrates that the person is ready to take action. Lack of involvement in the planning might cause difficulties later. The re creation of a new self image demands that the individual be included in every aspect of the psych rehab process.

ENVIRONMENT CHOICE
What will be needed for the person to function in the specific environment where he or she chooses to live, work or socialize. Symptoms or negative behaviors are not problematic in the environment of choice and may not be given a high priority. This represents a big difference from past pre vocational training.

The challenge is to get the person comfortable, successful and satisfied in the environment.

PSYCHIATRIC REHABILITATION READINESS
Readiness refers to an individual's desire and motivation to pursue some aspect of psychiatric rehabilitation. This is different from the medical model which is a prescription. This prepares and explores the options and alternatives with the person.

Rehabilitation is generally carried out in partnership with the person.

An important factor working against psychiatric rehabilitation readiness for many people is the lack of knowledge about themselves, about their environment and about supports that are available.

Some people are so used to being mental patients that are comfortable receiving services and do not want to change positions.

When looking at a career most people do not think about their likes and dislikes. Most people with mental illness have an impairment from the illness. So they would experience more difficulty in making choices.

READINESS ASSESSMENT
Need for change
Commitment to change
Environmental awareness
Self-awareness
Closeness to practitioner

REHABILITATION DIAGNOSIS
Overall rehabilitation goal
Functional assessment
Resource assessment

By looking at the range of choices, a person can determine their rehabilitation goal. Once the factors are determined, the matches between the environment and the individual will be evident and an appropriate goal will be set.

The diagnostic process can be carried out in several different ways. Most typically it is carried out through meetings with the consumer and and Psych Rehab worker.

Some sites bring the consumers together in groups and have them talk and discuss what might be some rehab goals and assessments.

Trying to come to the understanding of the rehabilitation goals in real life settings is extremely important.

FUNCTIONAL ASSESSMENT

At this point the consumer try to come to terms with what are the skills and behaviors which are strengths and weakness for the environment of choice.

RESOURCE ASSESSMENT

The availability of resources that can help the consumer achieve his or her goals must also be assessed. Learning and assessing resources is an education in itself.

REHABILITATION PLAN

The rehabilitation plan sets forth the skill and resource goals and objectives that consumers must achieve to operate in the environments they choose.

The rehabilitation plan is
a. The decisions that the consumer has made about what environments he or she wish to operate in.
b. The functional and resource assessments
c. Knowledge about the best path to take to achieve these goals

REHABILITATION INTERVENTIONS

These are specific strategies for acquiring needed skills, behaviors, and resources. This is the information that is usually recorded in the individual service or treatment plan.

When goals are more quantifiable they are more easy to justify.

The example of a person on the telephones. She only has an 85% success factor of taking messages. She is trying improve this taking message success factor to 95%.

SKILL ACQUISITION AND DEVELOPMENT

For each individual, there are needs to perform certain skills at certain levels. These skills need to be learned and developed. This is especially true when the person has been discourages over a certain period of time.

Remembering that many people to simultaneously cope with the environment and their psychiatric condition.

SKILLS TRAINING AND DIRECT SKILLS

Skills Training

Purpose foundation Components

Learning theory, behavioral therapy, and assessments
Determination of skills deficits in a targeted area
Acquisition-person can perform target behaviors
Generalization-person can perform target behaviors in target environment.
Maintenance-person can perform target behaviors in time
Impact-the new skill plays a meaningful role in the person's life

Techniques

Instructions-specific directions or requests to elicit behavior
Modeling-demonstration of skill and competent behavior
Role play-practice of skill
Feedback-strengths and weaknesses presented with encouragement and reinforcement.
Homework-assigned practice with feedback and reinforcement

Direct Sills Training

Purpose Foundation Components

Skill development
Education-teaching as treatment
Assessment-determination of skill performance requirements of clients performance in relation to environment requirements.
Acquisition-person can perform the skill as needed
Generalization-person can perform the desired skill as needed in his or her environment
Maintenance-person can perform the skills as needed over time
Impact-the new skill increases the person success and satisfaction in his or her environment.
Orient person to process-comprehensive explanations and descriptions of skill performance.
Show-demonstration of skill and specific behaviors
Do-practice competent behaviors and performance
Critique-interactive discussion about strengths and weaknesses of skills performance with encouragement and reinforcement.
Skill programming-identification to barriers to successful skill performance.

ROLE MODELING

One of the best ways to learn is through role modeling. We do and can learn our behavior from other people.

Role modeling is also part of the reason that many Psych Rehab Practitioners reduce obvious differences between them and the people who they serve.

Social Learning Theory
Albert Bandura formulated this special paradigm.
1. Instruction
2. Modeling
3. Role playing
4. Behavioral rehearsal
5. In-vivo practice

A CLIENT CENTERED APPROACH

Based on Carl Rogers in the 1940's came up with what was a distinct departure from the psychoanalytic therapies. This was to not directly instruct the person based on therapist's theoretical beliefs but to help the person understand their own belief system and promote positive change through trustworthy relationships.

Client centered therapy asserts that the opportunity for growth exists within the relationship which offers empathy, positive regard and genuineness.

Client centered therapy focuses on the client's perception of his or her present circumstances and assists the client in identifying his or her own answers to problems or barriers.

BEHAVIORAL STRATEGIES

Behaviorism was popularized by BF Skinnner. Reward for the good. Punish for the bad. The use of punishment causes unwanted behaviors to become more pronounced through resentments.

Rewards are very important in the context of rehabilitation. People feel rewards are meaningful when they believe that they represent real achievements.

SKILL GENERALIZATION AND SKILL MAINTENANCE

Skill generalization. Just because a person can perform a skill in one environment does not mean that they can perform the skill in other environments. This has been one of the main draw backs to pre vocational training. People who demonstrated these skills when in pre vocational placement did NOT transfer these skills to the full time employment.

Skill maintenance. People need to keep using their skills or lose those skills. People who enter into a center where there is only therapy and no work orientation, seem to lose their work skills. The concept of using skills based psych rehab interventions also provide skills maintenance.

PRINCIPLES OF SKILLS DEVELOPMENT

1. Use natural reinforcers present in the relevant environment to reward appropriate response in the training environment.
2. Provide support services to the client in the environment.
3. Teach support persons to use the skill of awarding selective rewards in the relevant environment.
4. Teach the client to identify intrinsic motivation(enjoying the task)as a replacement for extrinsic reward(pay or benefits).
5. increase the delay of the reward gradually.
6. Teach skill performance in a variety of situations.
7. Teach variations of the skill use in the same situation.
8. Teach self evaluation and self reward.
9. Teach the rules or principles that under lie the skill.
10. Use gradually more difficult homework assignments.
11. Involve the client in setting goals and selecting intervention strategies.

RESOURCE DEVELOPMENT

Some people might need public entitlements, such as Social Security. There are many resources out there. What resources are needed and how to access them is full education in itself.

Interdependence, Independence and Dependence

Where are the lines and what is really needed?

ENVIRONMENTAL MODIFICATIONS

Some of these modification might require a job coach, time for natural supports, make allowance for medical needs.

EVALUATING REHABILITATION PROGRESS

Evaluating takes place about every three months. Practitioners can see if the person comes to program or shows up at work. There are other features of progress which might be more difficult to understand. How do we measure a person's sense of well being?

SUMMARY

Rehabilitation begins with consumer choice. What are the choices and how to make decisions which will satisfy the client.

Once a goal has been established the PsyR Practitioner helps evaluate the goal to see what skills will be required(wanted or needed), what environmental supports will be required(wanted or needed), and the resources that can be made available.

Skill teaching and modification can be achieved through a number of strategies including role modeling, direct skills, teaching and behavioral techniques. The basic approach is client centered which respects the consumer.

CHAPTER SIX

PSYCHIATRIC REHABILITATION DAY PROGRAMMING

INTRODUCTION
This chapter will examine the history and development of state of the art psychiatric rehabilitation day programs.

1. What is Psychiatric Day Programming
2. When did Day Programming begin and how did it develop?
3. What are the common elements that make up a Day Program?
4. What is Milieu Therapy and how does it work?
5. How can programs be designed to produce specific outcomes?

Psychiatric Rehabilitation day programs are based on the premise that an environment can be created and will continue the recovery and rehabilitation of persons with severe mental illness. This program is not supposed to be a new institution.

There are three separate philosophies
1. Clubhouse movement Members attend these locations. They are in the community and take on almost no character of a mental health program. The activities are almost all social.
2. Partial hospitalization
The treatment of many people in the Community needed a a more structured setting that was in the community. It was found that many people could go home at night but needed a place to go during the day.
3. Milieu therapy represents a treatment style. This is seen as a more open floor approach. There is open access to the staff and rooms where people receive services.

All three approaches believe that people working together in an open environment create the opportunity to advance recovery.

THE ORIGINS OF DAY PROGRAMMING IN THE UNITED STATES

Todays state of the art for psychiatric rehabilitation day programming is a mixture of both the clubhouse and partial hospitalization movement.

THE DEVELOPMENT OF CLUBHOUSE PROGRAMS
In the 1940's a group of people who had been released from Rockland State Hospital started meeting on the steps of the New York Public Library. They called themselves We Are Not Alone(WANA). This was first only staffed by the members. The first

professional non staff person was hired in 1955. After trying several different directors, John Beard was hired and stayed the director until his death in 1982.

John Beard helped change the clubhouse into more of a psychiatric rehabilitation model. Today there are around 300 hundred Club Houses across the United States.

The Club Houses exist primarily to improve the lives of the members. Members were accepted without regard to their symptoms and did not have to improve to receive their member status.

By contrast, many partial hospitalization programs have prescribed length of stay and our discharge if their clinical state improves.

The clubhouse emphasis on work leads to other outcomes, such as member empowerment and the development of self efficacy(being able to produce results) and self esteem.

CLUB HOUSE STANDARDS

In 1989, the clubhouse standard were designed by the involvement of clubhouses across the country.

SOME SELECTED STANDARDS FOR CLUBHOUSE PROGRAMS

Membership
-Membership is voluntary and without time limits
-Members choose the way that they want to utilize the clubhouse and the staff with whom they work. There are no agreements, behavioral contracts, schedules, or rules intended to enforce participation of members.
-Members AT THEIR choice, are involved in the writing of all records reflecting their participation in the clubhouse. All such records are signed by both members and staff.

Relationship
-All clubhouse meetings are open to both members and staff. There are no formal member-only meetings or formal staff only meetings where program decisions and member issues are discussed.
-Clubhouse staff have generalist roles. All program staff members share employment, housing, evenings and weekends, and unit responsibilities. Clubhouse staff members do not divide their time between clubhouse and other responsibilities.

Space
-All clubhouse space is member and staff accessible. There are no staff-only or member-only spaces.

Work ordered day
-the work-ordered day engages members and staff together, side by side, in the running of the clubhouse. The clubhouse focuses on members' strengths, talents and abilities: therefore the work ordered day is inconsistent with medication clinics, day treatment, or therapy programs within the clubhouse.
-All work in the clubhouse is designed to help members regain self-worth, purpose, and confidence, it is not intended to be job specific training.

Employment
-The clubhouse enables its members to return to normal work world through transitional employment; therefore, the clubhouse does not provide employment to members through in-house businesses, segregated club house enterprises, or scheduled workshops.

PARTIAL HOSPITALIZATION

The first idea of hospitalization came from Stalinist Russia. There were too few hospital beds after the revolution and the civil war. People discovered that they could attend the day programs and go home at night.

Many of the early programs(two of the first were the Yale University Clinic and Menninger Clinic) started with a psycho analytic perspective, emphasizing group therapy and individual therapy, expressive therapy, such as dance and art.

After attendance for a period of time, people possibly were deemed more appropriate for insight-oriented therapeutic approach.

THE DEVELOPMENT OF PARTIAL HOSPITAL PROGRAMS

Partial hospitalization was originally funded by the federal government to help get people out of the hospital. Later on the partial hospitalization programs were to be funded by Medicaid and/or Medicare. The money never quite followed the people into the community. The staff was poorly trained and was not prepared to deal with people with severe mental illness. These programs were and still are very medical model programs.

MILIEU THERAPY

Day programs were largely based on programming called milieu therapy. This means that every aspect of the treatment facility can be used for therapeutic and rehabilitation goals. Milieu strategy tasks can be ensuring that the physical environment is inviting, comfortable and clean: planning a recreational event that will encourage high interaction between people.

Milieu Therapy is the use of the whole physical, social, and cultural environment in the the therapeutic process. In Milieu Therapy the environment is the essential treatment component. Milieu Therapy was seen as important because the environment can be greatly magnified due to nature of mental illness.

COMPONENTS OF PSYR DAY PROGRAM

Some people see these programs as laboratories where new programs can be developed. Other people see them as not standardized programs and hard to evaluate.

CIENTS OR MEMBERS
-Clients or members should be diagnosed with a severe and persistent mental illness. They should be in the least restrictive environment. They should not be hospitalized unless they are danger to themselves and others
-Clients or members of a program should have a history of either long or repeated hospitalizations. They can also have failed to function in the community
-Clients or members should not be a danger to themselves or others.
-Clients or members should be able to tolerate the Milieu.

STAFF
-Director sets the tone of the program. The specific tasks might be supervising daily operations, program design, supervising staff and recruiting staff.
-Supervisory level staff are people who are in charge of different lines in the program. They often hold a Masters Degree in a specific program.
-Counselors, Case Managers are the line staff. These are people who spend most of their time working with people.
-Mental health aides or paraprofessionals are workers who drive vans, do outreach, help out with activities
-Auxiliary staff are psychiatrists, vocational counselors, etc
-Support staff are the secretaries, room clerks, accountants.

SPACE
There should be enough space to carry out activities and also do office work, also.
Should be well lighted
Should have reasonable access to public transportation

PROGRAM INGREDIENTS
Socialization skills, skills training, education about wellness and symptom management. Better programs have a mix of skills training, vocational activities, support and recreation depending on the individual.

SCHEDULING
A program should be in line with its philosophy and values.

EVALUATING PSYR PROGRAMS

A PSYR DAY PROGRAM TAXONOMY

taxonomy
• the classification of something, esp. organisms : the taxonomy of these fossils.
• a scheme of classification

How is the program structured? Can you describe that classification? For instance, a program with work more in the forefront might have vocational components structured through the day. Work might be scattered through the taxonomy.

THE EFFECTIVENESS OF PSYR DAY PROGRAMS

Day programming with high patient (person) turnover and more intense treatment may lead to relapse for some people with psychiatric conditions.

People also found out that the cost of people who were receiving day programs and medication was less than people who were only on medication. The lower cost of the treatment was that people were receiving less inpatient services.

Basically, those who are homeless and mentally ill or remain unaided by medication community mental health might be a disaster. For those who can function with some degree of independence but still need services, community treatment can be liberating.

STATE OF THE ART PSYR DAY PROGRAMS

There is starting to be a blend of these programs. From the clubhouse movement, we get respect for one's life, employment, housing, social supports and membership in the community. People from the clubhouse group belong to USPRA.

There are less divisions between people's philosophy

Partial hospitalization people get the emphasis on medication and medication management. Symptom and mental health education is part of the program.

What is Empowerment and what does it do?

There might be a strong client committee or governing body, members might hold supervisory positions and might collect data to evaluate the programs.

Does speaking about empowerment mean the program is empowering?
According to the research-probably not.

Although empowerment is important there is no agreement on how to measure it.

THE FUTURE OF DAY PROGRAMMING

The future of day programming depends on funding sources and what they are willing to pay for. Day program will survive if it meets the needs of the clients. Also, the clients need to be vocal in their support of good day programs.

The value of one program providing all these services is simple. All is under one roof and there is ease in accessing these services.

The disadvantage is that community integration may be lost. For instance, depending on a program for recreation might mean that the person never goes out into the community.

SUMMARY

Clubhouses, Partial Hospitalization and Milieu Therapy all had roots in the deinstitutionalization movement.

Programs believe that people coming together can solve common problems.

Research has shown that some programs(focus on the here and now and less formal therapy) produce outcomes that are superior to medication alone. Research has shown that these programs are economically efficient. Today's state of the art program is a combination of elements of state of partial hospitalization(emphasis on medication and treatment), clubhouse movement(emphasis on quality of life and empowerment). Many programs have grown into multi service agencies which attempt to provide for all.

CHAPTER SEVEN
ASSERTIVE COMMUNITY ACTION TEAMS

INTRODUCTION
1. Why do psychiatric rehabilitation services need do much coordination?
2. What are case management, outreach, and assertive community treatment?
3. Why are these approaches essential to psychiatric rehabilitation?
4. How do assertive community treatment and case management differ?
5. What is the evidence that these approaches are effective?

Deinstitutionalization, the national policy for discharging people from the state hospitals began in ernest in the 1970's. 1970 to 1975 there were 100,000 people discharged into the community. By 1985, psychiatric inpatients had been reduced by 450,000.

The stays were also shorter for new admissions. This began recidivism. The revolving door of people going in and out of the hospital. This problem was compounded by the money staying to fund the hospital rather than going out in the community with people who were discharged.

Mental health planners found that it still cost the same amount of money to run the hospital at 30% capacity as it did at 100%.

Deinstitutionalization was seen as a failure and criticized. Many people had more legal rights but also had decreased quality of life. The President's New Freedom Commission said that these problems exist today. And, the system where people are discharged is very fragmented and in need of significant repair.

THE NEED FOR CONTINUITY OF CARE
As with any broadly disabling condition, the person with mental illness needs a wide scope of services.

Major continuity of care was needed when people moved from centralized hospital environments to multi agency environment in the community.

For some people, that continuity of care was lost in deinstitutionalization. People had medical needs. There were house keeping staff and recreational workers all in one large place-the state hospital. Today, the community services are provided by a variety of different people and services who often do not communicate with each other.

A person in the hospital was provided for. On the outside, people are given a monthly check and goes around town to different programs and different appointments.

In the community there is Diffusion of Responsibility. Each person and each agency thinks that it is the job of another person and another agency. Many consumers have ended up returning to the hospital, ended up living on the streets, or become homebound recluses. Nobody meets their needs.

Many of the services were new and were also office bound services. People did not know how to link people to community services.

Many people found that these services did not exist. Vocational support systems were in short supply during that time.

There are still major gaps in service programs. There is poor coordination in service system programs. There is high stress upon release from the hospital. This may cause high rates of recidivism or decompensation. There is not follow up after discharge and connect people to services. Many people have to make connections by themselves right after discharge from hospital. Is it any wonder that there is recidivism?

AWARENESS OF THE NEED FOR CARE COORDINATION AT THE NATIONAL LEVEL

1979-The National Institute of Mental Health(NIMH) created the Community Support Programs(CSP). These programs tried to design programs to meet the needs of people in the community.

CASE MANAGEMENT

The term case management can mean widely different things to people. The term case manager became an issue with consumers. They did not want to be a case and did want to be managed. Some people have suggested the term care management be used. Care Coordinator is another term which is suggested.

-Continuity of care The individual receives services over a period of time.
-Accessibility The person can enter and use the services he or she needs.
-Accountability The system accepts responsibility for the services provided.
-Efficiency Services are provided in an economical way.

The five basic functions of case management are

1. Assessing Identifying the client's (person's) needs
2. Planning Developing a comprehensive service plan for the person.
3. Linking Connecting the client (person) with services to be delivered
4. Monitoring Ensuring that the services are delivered
5. Evaluation Assessing the person's response to the services

A Community Support System has a wide variety of services

-Client identification and outreach
-Mental health treatment
-Rehabilitation services
-Crisis response services
-Housing
-Health and Dental Care
-Protection and Advocacy
-Peer Support
-Family and Community Support
-Income support and entitlements

THE CASE MANAGER
The case manager is a jack of all trades and single point of responsibility.
At best case management is the epitome of individualized services
The case manager meets the person on his or her own ground.

The case manager and consumer work together for an individualized plan. This plan should work together to have strengths and weaknesses be part of the plan.
The consumer should be reassured that someone is watching over their concerns.

One of the most difficult tasks is evaluating the consumers progress.

Finally, achieving goals may not signal the end of the process. Often new need arise.

MODELS OF CASE MANAGEMENT
EXPANDED BROKER MODEL
Staff depend on making referrals to other agencies. This traditional case management model uses assessment, planning, linking and advocating as the steps. Staff members become agents to steer people through different agencies or different steps in treatment program needs.

The staff person working in the direct broker model needs direct experience with community mental health services(including knowing key staff persons, program rules, and hours) is a must.

REHABILITATION MODEL
This follows the traditional rehabilitation approach. Emphasis is on the client achieve success in the community of their choice. Clients chose rehabilitation goals and also work on a functional assessment.

STRENGTHS MODEL
Strengths model is based on two assumptions
1. A person must be able to use, develop and access their own potential and have the resources to do this.

2. A person's behavior is dependent on the resources that they have available.

The case manager facilitates the person's pursuit of interests and opportunities of their choice to live in the community.

FULL SUPPORT MODEL (ASSERTIVE COMMUNITY TREATMENT MODEL)
Besides providing all the case management services-this model also provides many of the other community services. This is multi disciplinary team. There is typically a psychiatrist, nurse, rehabilitation counselor, substance abuse counselor and perhaps a peer counselor.

EVALUATING CASE MANAGEMENT
Numerous studies have been done to evaluate the effectiveness of case management. Kim Muesser and associates researched case management as ACT teams and Intensive Case Management (ICM) ACT teams share the case loads and ICM teams do not. This review found that these programs were effective at reducing times spent in hospitals and people were less likely to lose their housing. There was modest improvement in quality of life and improvement of symptomatology.

THE DEVELOPMENT OF ASSERTIVE COMMUNITY TREATMENT
In the 1970's Mary Ann Test, Phd. and Leonard Stein believed that people had the following needs which must be met

1. Material resources, food, shelter, clothing, medical care and so forth
2. Coping skills to meet demands of community life
3. Motivation to persevere and remain involved with life
4. Freedom from pathological dependent relationships
5. A supportive system that assertively helps individual with the preceding four requirements.

The original model was called Training in Community Living Model(TCL). This model was called hospital without walls as an alternative to hospitals.

Thirteen staff people met with 115 persons diagnosed with schizophrenic disorders.

These services were provided in the community at people's homes. This is referred to as EN VIVO or the client's real life environment. People were sometimes visited twice a day. The team also worked with other agencies, families, landlords or who ever was involved with the person's care.

The revolving door was seen as too costly. This model gradually spread through out the United States. This model had to be tailored. For instance, there might be more of a need for substance abuse knowledge. ACT teams, while not adhering to full staffing pattern, still adhere to the same model.

EVALUATING TRAINING FOR COMMUNITY LIVING

TCL participants spent average of 11 days in hospital while traditional treatment people were in the hospital about 37 days.

EVOLUTION INTO ACT

This has been outlined by Bob Drake and associates. This is a multidisciplinary approach. Twenty four hours a day. Seven days a week. Team approach is that some one who has some kind of knowledge is alway available. Usually, there in one ACT member for every ten people served. So, a group of 60 consumers would have six staff people.

-Case management and coordination of services
-Psychiatric services by psychiatrist or nurse
-All needed counseling and psychotherapy services
-Housing support services to help individual receive stable residence
-Employment and rehabilitation services

Services are delivered where ever the person can be found. The team meets the person. Also, the team does evaluation for any commitment.

An addition to many ACT teams is the inclusion of peer providers. Added to teams, the peer providers bring a unique perspective to the team. Clients randomly assigned to were more engaged in treatment and had lower rates of non compliance at appointments. With peer providers, they had higher levels of participation in structured social activities, transportation and access to health benefits.

WHEN IS A PROGRAM ACTUALLY ACT?

1. Services are targeted to a specific group of individuals with severe mental illness, usually those at risk for hospitalization, re hospitalization or relapse.
2. Rather than brokering services, all treatment and rehabilitation services are provided directly to the community treatment team.
3. Team members share responsibility for the individuals served by the team.
4. The staff to consumer ratio is small (approximately ten to one)
5. The range of treatment and services is comprehensive and flexible.
6. Interventions are carried out at the locations where problems occur and support is needed, “in vivo” (in real life) not in hospital or clinic settings.
7. There is no arbitrary time limit for receiving services
8. Treatment and support services are individualized.
9. Services are available 24 hours a day
10. The team is assertive in engaging individuals in treatment and monitoring their progress.

DO EFFECTIVE CASE MANAGEMENT PROGRAMS SHARE SIMILAR CHARACTERISTICS?

-Case managers should deliver as much of the help as possible themselves rather than refer to other providers.
-Case managers should have primary responsibility for a person's services
-Natural community supports(including people not paid to help the consumer)are the primary partners of the team
-Case management is done primarily in the community, as opposed to the office or program site.
-Caseloads should be small enough to allow frequent contact.
-Services should be time unlimited, if needed.
-The availability of familiar people, 24 hours a day- 7 days a week.
-Case managers should facilitate informed choice by the consumers they serve.

ASSERTIVE COMMUNITY TREATMENT: AN EVIDENCE BASED PRACTICE
ACT has many positive comprehensive services:
medication
counseling
case management
rehabilitation
substance abuse services

ACT is highly normalized. The stigma attached to going to a psychiatrist's office is removed. People have debated if having a professional arrive at home or the job might be just as stigmatizing.

ACT is multi disciplinary approach with a variety of team members to provide round the clock service.

Randomized clinical trails support that ACT is best vehicle to keep people out of the hospital.

For some people ACT is too coercive. ACT teams can be too medical model. ACT teams were seen by about 11% of the recipients in one study as too coercive.

ACT can be highly coercive and paternalistic like like court ordered treatment

CRITICAL INGREDIENTS OF ACT
1. Services are provided to the consumers in the community
2. Services are provided by a multi disciplinary team, rather than at clinics.
The team meets four to five times a week.
3. Services are not time limited.

4. Staff to client ratio is low
5. Services are offered fairly intensely with contact between staff and clients averaging four times weekly.
6. Supports are provided around the clock
7. Services emphasize medication management and personal everyday issues.
8. ACT controls, in part, the screening and evaluation for any needed psychiatric hospitalizations, participates on hospital treatment teams, and facilitates discharge planning.

SERVICE OUTCOMES OF ACT
1. Reduced hospital utilization
2. Increased housing stability
3. Possible increased quality of life
4. Possible consumer satisfaction with services

REVIEW OF ACT RESEARCH
Compared to case management, people served by ACT consistently spend fewer days in the hospitals than those provided by standard case management.

ACT AS AN EARLY INTERVENTION STRATEGY
Canada and England use this approach. This has helped turn around Duration of Untreated Psychosis (DUP). The longer a person goes without care and treatment, the more likely they are to have longer disabling symptoms of their psychiatric conditions.

ACT AND PERSONS IN THE CRIMINAL JUSTICE SYSTEM.

ACT has been linked to jail programs in Rochester, New York and Chicago, Illinois. Again, research has shown that these programs have demonstrated decreased arrest, lengthened time person spends in community and decreased over all costs.

ACT COMES OF AGE AS A PROGRAM AND A PROFESSIONAL STRATEGY
There is a ACT team organization (http://www.ACTassociation.org)

THE FUTURE OF ACT AND CASE MANAGEMENT APPROACHES
ACT will continue to improve. ACT will include more EBP's such as illness management. Motivational interviewing. Supported Employment Family Psycho Education. Gary Bond claims in his research that ACT teams seem to have little positive effect on social functioning.

Given the cost effectiveness, ACT teams will probably grow for two populations

The general population of people with mental illness.
The people with mental illness who are incarcerated.

ACT is more expensive than traditional case management and cheaper than hospitalization.

Services which are provided in the community are more Normalized than traditional day programs or supervised residences.

ACT teams allow the person to work in the community.

Consumers are not stigmatized by attending a day program.
ACT teams are focused on the here and now. They are focused on how to live in the community.

ACT teams can have consistency with Psychiatric Rehabilitation principles.

SUMMARY

Assertive Community treatment and case management programs were constructed because of high rates of recidivism. Evaluation has shown these programs are effective.
The role of the consumer will grow in these programs.

CHAPER EIGHT
DUAL DIAGNOSIS: SUBSTANCE ABUSE AND MENTAL ILLNESS

INTRODUCTION

1. What unique problems are faced when providing services to someone dually?
2. Why are such large proportion of people with mental illness at risk for substance abuse?
3. What barriers prevent the effective treatment and rehabilitation of individuals who are dually diagnosed?
4. What is the best way to provide services to persons with dual diagnosis?

This condition has been labeled Co Occurring Disorders, Co Existing Disorders, Mentally Ill Chemical Abuser (MICA) and Mentally Ill Substance Abuser(MISA).

People using substances have been in greater danger of medication non compliance, hospitalizations and homelessness. Also, higher rates of HIV infection.

More family problems by more disruptive behavior and violence.

HISTORY OF DUAL DIAGNOSIS TREATMENT
During the 1980's it was discovered that many people who were receiving mental health care were plagued by substance abuse issues.

Psychiatric symptoms were seen as a sign of illness while substance abuse was seen as bad behavior.

Mental health and substance abuse systems were seen as unsuccessful in treating both disorders.

People in substance abuse endorsed abstinence and would only work with people who were not using. Some people with substance abuse thought that medication was a drug.

Many people found that they could only get services from one system or the other. They could not get combined services. Mental health did not understand substance abuse and substance abuse did not understand mental health.

SEQUENTIAL SERVICES
The person receives services for one of the other services. When the first disorder is treated then the person goes on and gets treatment for the next disorder.

This has been found to be largely ineffective. The reason that many people use drugs seems to be not relief from symptoms but to improve social interactions, to be largely accepted by the peer groups and to alleviate boredom.

-The untreated disorder worsens the treated disorder, making it impossible to stabilize one disorder without attending to the other.
-There is lack of agreement as to which disorder to treat first
-It is unclear or impossible to know when when one disorder has been successfully treated because both disorders might need long time maybe life time treatment. The second treatment may never commence. The client has never been referred to further treatment.

PARALLEL SERVICES

Parallel services are services where the person is treated by different staff in sometimes different agencies.

The addictions staff lack knowledge and insight into mental illness and the mental health staff do not and can not seem to understand substance abuse.

Substance abuse rests on the confrontational model and while mental health rests on the outreach/supportive model. The person dual disorder might find themselves in two different systems with two different philosophies.

-Mental health and substance abuse are not integrated into a cohesive treatment package.
-Treatment providers fail to communicate with each other
-The burden of integration falls to the client
-Funding and eligibility barriers to participating in both treatments simultaneously exist
-Different treatment providers have different treatment philosophies
-A client “slips between” the cracks and receives no services, due to the failure of either treatment partner to accept responsibility.
-Providers lack a common language and treatment philosophy

INTEGRATED SERVICES

This change toward integrated services started around 1998. This was a big change for many people. Integrated services are now seen as Evidence Based Practices.

FUNDAMENTAL TREATMENT STRATEGIES IN PROVIDING INTEGRATED DUAL DISORDERS: STAGES OF DEVELOPMENT

Prochaska, Norcross, and DiClemente designed the trans theoretical model of behavior change. The time may vary for each stage but the sequence does not. In each stage the individual is involved in different tasks.

PRE CONTEMPLATION
This is the stage where people believe that they do not have a problem. They may demoralized by their behavior. They may be unable to envision alternatives. They have conflict in their personal relationships, in ability to meet obligations, poor health

The treatment task with a person at this stage is to help them become aware of the problems associated with their use of substances, in other words to raise doubts within the individual. This may be used by using a technique called Motivational Interviewing.

CONTEMPLATION
In the contemplation phase, people have expressed ambivalence about their condition. They are aware that there are costs about their behavior. The cost are outweighed by actions. They are not willing to take charge. People will move toward being better by moving toward change.

The tasks at this stage are to help the individual outweigh the benefits of continued substance abuse. This may also be accomplished by reinforcing or increasing the benefits of change, for example by getting a job or acquiring new friends.

PREPARATION
Preparation stage people need to easily recognize the need to change. They have decided to make changes in the new future. They still have some ambivalence. A program or person who mandates abstinence with someone at this point will be unsuccessful. The more successful approach consists of helping to identify the steps to take and helping to identify the supportive counseling to sort through the continued feelings of ambivalence.

ACTION
In action stage people are taking definite steps toward changing the behavior change and are acquiring new behaviors. Building strategies for people to remember why they want to change, and are changing is helpful. The person with the dual disorders at this stage might be learning new avenues for social interactions, taking on new responsibilities, or accessing vocational or employment opportunities.

MAINTENANCE
In the maintenance stage people have sustained change for a while and are working toward preventing relapse.

There needs to be realistic expectations of the possibility of relapse. Prochaska and colleagues found out that only about 20% of people expressing desire to make change are ready to make that change.

Again, they found out that the time in each stage of change might vary for different people, the tasks, processes and sequences do not change.

STAGES OF CHANGE
The task of the psychiatric rehabilitation practitioner is to help a person move though these stages of change. A specific strategy has been Motivational Interviewing.

MOTIVATIONAL INTERVIEWING

Defined as “client centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.”

The practitioner uses motivational interviewing to nurture the person’s motivation to change. Motivational Interviewing helps end the discrepancies between goals and actual behaviors.

Motivation Interviewing is based on four principles
1. express empathy
2. develop discrepancy
3 roll with resistance
4. support self efficacy

The practitioner does not argue for change when met with resistance. Ambivalence is natural and the person is encouraged to succeed in goals in resolving discrepancies between past and future behavior.

The practitioner always commits to the belief in the person’s ability to change.

Motivational Interviewing fits into the the EBP’s. Most psych rehab practitioners use Motivational Interviewing today.

PRINCIPLES OF TREATMENT FOR PEOPLE WITH DUAL DIAGNOSIS

1. Integrated Treatment: Mental Health and Substance Abuse are provided concurrently by the same clinician or clinical team.
2. Stage-wise Treatment: Treatment is relevant to the stages of development. Bob Drake describes the stages as engagement, persuasion, or motivation, active treatment or relapse prevention.
3. Engagement Intervention: Services use strategies that increase the likelihood of engagement of treatment for the group of people who have difficulty engaging and sustaining engagement.
4. Motivational Counseling Intervention: Services use counseling which move people toward individual goals.
5. Active treatment interventions: Services include interventions such as motivational counseling, cognitive behavioral counseling, or family interventions which are meant to develop individuals to manage their own illness by developing their own skills and support.
6. Relapse prevention intervention: It is well known that there are relapses with substance abuse. This puts into place a plan for prevention of relapses.

7. Long term perspective: Services are designed to promote retention(provide active outreach, are flexible to tolerated periods of relapse) recognizing that recovery is a long term prospect.
8. Comprehensive services: Services address the individual's needs in all life areas.
9. Interventions for treatment of non responders: Services include specialized or modified options for each individual. Some of these may include dental treatment, family interventions, trauma interventions and money management.

DUAL DIAGNOSIS TREATMENT IN GROUPS
Several groups have emerged in the treatment of Co Occurring Disorders
1. 12 Step Recovery
2. Stages of treatment developed by Prochaska and collegues.
3. Motivational Interviewing
4. Social skills training
5. Cognitive Behavioral Intervention
6. Broad based educational support meetings.

INTEGRATED SERVICES: AN EVIDENCE BASED PRACTICE
ELEMENTS OF THE EVIDENCE BASED PRACTICE: INTEGRATED DUAL DISORDER TREATMENT
1. Concurrent treatment of both conditions by the same clinicians.
Clinician must have training in both fields-mental health and substance abuse
2. Assertive outreach
Actively seeking people in their own environments
3. Motivation based intervention
This is based Miller and Rollnick based on how the person feels about their condition and how they want to change it.
4. Reduction in negative consequence(Harm reduction)
This is almost against the hit bottom theory. Hitting bottom can be very dangerous. Most people do not get clean and sober over one day. There is some progress.
5. Comprehensiveness This means help with money, new social life, new housing, new opportunities in life.
6. Cultural sensitivity and competence This element should be in all services

OUTCOMES OF THE EVIDENCE BASED PRACTICE
Outcomes of the EBP model has been shown to be superior to parallel or sequential model

SUMMARY
Recognition that people with severe mental illness might be vulnerable to substance abuse problems came about after deinstitutionalization. For some time there were few if any programs for people with substance abuse issues.

The system tried both parallel and sequential approaches and neither seemed to work
Integrated treatment using treatment stages and motivational interviewing works best.

CHAPTER NINE
VOCATIONAL REHABILITATION

INTRODUCTION
1. What are the barriers to employment for people with a psychiatric disability?
2. What skills, resources, or experiences are related to vocational success?
3. What constitutes vocational services?

Employment is an essential adult activity. Working promotes pay, self esteem, status in the community, and economic well being. It also seems that work leads to symptom reduction, community integration and improved functioning.

Self esteem seems to improve when people have a job which they like feel satisfied with. Yet, employment rates for people with mental illness are very low. Only from 0% to 30% of people who have a mental illness are employed

BARRIERS TO EMPLOYMENT
STIGMA AND DISCRIMINATION
One of the greatest barriers to employment for people with psychiatric conditions is stigma. The biggest cause of stigma seems to be the negative characterization of people with mental illness in the media.

Most people with disabilities reported that they did not participate in the community because they were not asked or invited.

Another prejudice comes from people who work in the field. There are people who work in mental health who feel that people in our mental health programs can only do small amounts or NO work.

Plus, there is a lot of self stigma from people with mental illness themselves. People with mental illness have bought into the stigma.

MISGUIDED SERVICES
Uniformed beliefs about people with mental illness kept many people from the work force.

Concerns about stress, symptomatology, medication compliance and re hospitalization have caused concern with many professionals. Research has shown that competitive employment does not increase symptoms. Many people expect the person to demonstrate motivation before they look for employment.

LACK OF VOCATIONAL EXPERIENCE
Another barrier to work is many people with mental illness have barriers to work because they do not have the confidence that people need. Because people do not have the job experience, they might not be able to describe what they are good at doing. Some vocational opportunities might be missed.

LACK OF EDUCATION
Lack of work experience might have also interfered with someone's education,also.

PSYCHIATRIC DISABILITY
Sometimes the inability to work might part of the mental illness. The mental illness has an impact on thought and affect.

There are also difficulties with memory and also getting along with other people.

POSSIBLE LOSS OF BENEFITS
Most people realize that if they work that they could lose their benefits. Make sure that a benefits specialist is involved. Make sure that each psych rehab practitioner realized that loss of benefits is a real concern.

DEVELOPING EFFECTIVE VOCATIONAL SERVICES
FEATURES OF EFFECTIVE VOCATIONAL SERVICES
Several researchers have tried to guide what might be effective vocational services by identifying predictive vocational success.

Some people have felt that past work experience is a predictor of future ability to work. Again, level of symptomatology was not related to finding and holding a job(vocational success). However, in some other studies, symptomatology was related to vocational success. Some studies found that medication does impair ability to work.

A growing number of studies shows that the specific model of service seems to be a contributor to success. Supported Employment seems to do better than any other models.

Also, the idea of pre vocation training or placement seems to be an idea that is not respected today.

High performance Employment Program Characteristics
Beliefs and viewpoints

1. Emphasize the possibility of work
2. Do not view societal stigma as barrier to performance.
3. View the consumers as willing to work and ready to work
4. The potential loss of benefits is seen as need for information and negotiation rather than major barrier

Practices
1. Emphasize strength based practice

2. Use employment outcome data to improve services
3. Share stories that reflect the person's ability to succeed.
4. Conduct frequent and regular meetings between vocational and case management staff
5. Case managers are proactive in their support of employment goals and efforts.
6. Therapists support or employment goals.

Know about Vocational Rehabilitation and Americans With Disability Act.

With ADA these are part of what is necessary for ADA and psychiatric disability
1. Human assistance including job coach, co worker support, or mentoring
2. Changes in workplace policy such as allowing telephone calls, using sick leave for emotional illness, setting up a quiet workplace for some one whose concentrations are distracted. Another might be holding a job for someone who might be out for awhile. Job sharing and allowing the worker to set his or her work pace.

Providing supervision and management skills on how to deal with ADA

Shaping co workers attitudes

VOCATIONAL SERVICE MODALITIES
The Fountain House established vocational services as an important part of the mental health program. The members work alongside of staff to make the clubhouse work. The club house also have pre vocational service units to be part of the vocational services.

TRANSITIONAL EMPLOYMENT
TE jobs are typically part time and require minimal skills so that a wide variety of members can take part in the employment.

The members earn a paycheck and get some work experience. Program members may go through a series of TE jobs. The Fountain House lets members have as many jobs as possible in the TE unit. TE has been an important fore runner to supported employment.

FAIRWEATHER LODGES

These were enclosed communities which had people working on the inside and making a contribution to the community. The lodge community based itself on the importance of autonomy, advancement, tolerance, support and similarity to the larger society.

Historically referrals came directly from the hospital. Some people are allowed to continue the work program after they leave the lodge and some people are able to be in the work work program without ever being in the residence.

HOSPITAL BASED WORK PROGRAMS

Some sites have given people the chance to work in the hospital during periods of hospitalization. Most researchers seem to agree that there is no correlation between successful adjustment to work programs in the hospital and success in post hospital deployment.

JOB CLUBS
The club provides resources, training and job-seeking-skills(resume writing, interviewing, etc.) An important part is the job club provides the consumer with peer support.

SHELTERED WORKSHOPS
Sheltered workshops solicit manufacturing job from local businesses and provide support and supervision to people in a factory like setting. For some people sheltered workshop is supposed to be a step toward competitive employment. For some people, this has been a permanent placement.

Sheltered workshops have come into criticism in past few years since many people today believe that almost all people are ready for supported employment.

AFFIRMATIVE INDUSTRIES
These are industries which are run by the agency and employee people. These can range from commercial cleaning or landscape crews to bakeries and caterers. The people are managed by the people at the agency. Similar to Affirmative Industries are client employing businesses which employ people with psychiatric disabilities-these may also employee people who do not have disabilities.

SUPPORTED EMPLOYMENT
Supported Employment is really part of the social movement. It represents inclusion of people with disabilities into the social fabric.

Supported Employment started with people with the most severe psychiatric disabilities. People with even the most severe disabilities could work. The new place-train approach reversed the train-place approach. Although the psychiatric disability seemed to make the train-place approach necessary, this was really not proven successful.

In 1987, Karen Danley and Bill Anthony came up with the Choose, Get, Keep approach.

Gary Bond and his associates found that when workers were in jobs that matched their preferences that they stayed twice as long. The combination of choice and support(either on or off site) has been the hallmark of Supported Employment. The underlying philosophy is that anyone given the adequate supports is capable of competitive employment.

THE ROLE OF THE JOB COACH

Regardless of the Supported Employment approach, the primary person to supported employee is the job coach. Today supports provided off the site are more effective ways to provide supported employment.

Over the years there has been increasing recognition of the highly professionalized role that the job coach plays.

Usually working without supervision, the job coach has to provide many different tasks.

This can be career planning and development.

Taking a broad view the job coach must accomplish many different tasks. Marketing and job development. Understand the business community and provide employees. In some case cases the job coach will teach the job acquisition and/or how to prepare a resume.

Some research indicates that up to forty two contacts are needed to generate one job offer. The job coach may have to interact with doctors, community members, other family members and others.

The job coach must be flexible and meet with a variety of different people in a variety of different places.

MODELS OF SUPPORTED EMPLOYMENT

In a relatively brief period of time, a variety of Supported Employment models have become available to people. Sometimes Supported Employment is just added on to the agency and this causes differing values and priorities. Sometimes, the ideology with Supported Employment is too standardized and can not succeed.

INDIVIDUAL PLACEMENT MODELS

The individual placement model is the most individualized. The IPS model emphasized rapid job search, and the integration of social and clinical services. Whereas, the Choose, Get, Keep model emphasized skill development and career planning.

In both, the person is engaged and the people in the client's life are listened to. The person's skills, preferences interests and resources and supports are utilized.

Clients help identify the past experiences so that their skills are identified and developed. This also is place-train model. The job coach is not the only person who works with the client. The job coach knows, develops and strengthens the network of the person receiving the services.

The level, type and frequency of support needed by the supported employee will and should change over time.

AGAIN, IPS model emphasized the integration of clinical services and vocational services.

Recently the Choose-Get-Keep has added on LEAVE. A person can and might want to leave their job.

ENCLAVE OR WORK CREW MODEL
The Supported Employment model places a small group of people in work crew. The Rehabilitation Act specifies that no more than eight people with disabilities can be on a work crew. Although, in place of business or in the community, it is also self contained model. This reduces chances for interaction and increases chances for stigma.

SUPPORTED EMPLOYMENT IN ASSERTIVE COMMUNITY ACTION TEAMS
ACT Teams often have an employment specialist or vocational component. A basic component believes that there is a direct relationship between vocational functioning and symptoms. A person who is working is less likely to be pre occupied with his or her symptoms.

OTHER VOCATIONAL PREPARATION SERVICES

VOCATIONAL EXPLORATION SERVICES

Tours of business
Volunteering
Job Sampling
Job shadowing
Informational interviews
Work site interactive internships
This goes beyond just finding a job and goes into finding a career opportunity. Consumers are assisted in exploring their own general occupational limits. This field is tested by an internship in the field.

Research has shown that Supported Employment has superior outcomes to any other employment model.

CRITICAL INGREDIENTS OF SUPPORTED EMPLOYMENT
Services are focused on competitive employment
Non exclusionary criteria
Rapid job search
Integration of vocational and mental health services
Focuses on consumer preferences
Time-unlimited, individualized supports

Benefits counseling

SERVICE OUTCOMES OF SUPPORTED EMPLOYMENT
Competitive employment
Higher number of hours worked
Higher wages earned

Services with Supported Employment seem to get 60% to 70% percent of people jobs.
What factors inhibit people from getting work?
What supports will improve retention?
What is the role of non SE providers in promoting and supporting employment goals?

SUMMARY
The barriers to people with mental illness working include stigma, the experience of symptoms, disabilities brought about by the illness, and concern about the loss of government benefits.

Stigma reduces community acceptance of people with mental illness and results in discrimination. Stigma also reduces quality of services and options. There can also be internalized stigma.

Many people with mental illness have missed out on many vocational experiences through the years.

Innovative psych rehab services were introduced by Fountain House (TEP) and Fairweather Lodge (Living together and working together)

In the 1980's Supported Employment was introduced into the field of psych rehab. Employment focuses on competitive employment, non exclusion, rapid job search, integration of vocation and clinical services, consumer preferences, time unlimited supports, and benefits counseling as a major ingredient.

In the United States, the Rehabilitation Act of 1973, which established the Rehabilitation Services Administration. In 1990, The Americans With Disability Act was passed. This act is a far reaching statement about the right and ability of citizens with disabilities to be included in all community activities.

CHAPTER TEN
SUPPORTED EDUCATION

INTRODUCTION

1. Can people with severe and persistent mental illness successfully pursue post secondary education.
2. What are the special needs of students with psychiatric disabilities? What types of special services and supports can be provided?
3. What does higher education offer persons with severe and persistent mental illnesses?
4. Are there supported education strategies that have been proven effective?
5. What is the future of supported education as a psychiatric service?

A common consequence of schizophrenia and other severe mental illnesses is the disruption of education. The inability of achieve an important personal goal such as education of results in feeling failure, shame, and disappointment.

It also important to consider the impact of interrupted education on earning and having a good job.

BENEFITS OF SUPPORTED EDUCATION

1. New identity Moving into a valued role as student is important
2. New and normalized environment Moving from the mental health world to the academic world.
3. Structure School offers meaningful ways to structure ones life
4. Clean slate Often an employer asks what a person has been doing during the years, a person can say going to school.
5. Hope Enrollment in college classes and progress toward degrees are major steps toward realization of goals and dreams.

For many people, supported education can be an important step toward realization and goals that were thought impossible.

BARRIERS TO EDUCATION
Clearly supported education has the capacity to greatly enrich the lives of the people with psychiatric disabilities.

One barrier is economic instability. People who are struggling with money will have more difficulty.

Affordable transportation Lack of transportation is cited as number one obstacle to not going to school.

Balancing school work with other responsibilities. Home, jobs, children and other responsibilities limit a person's ability to work.

UNIQUE CHALLENGES FOR PERSONS WITH PSYCHIATRIC DISABILITIES
Probably the most unique challenge is the mental illness. Hallucinations and delusions can have a big negative effect in one's life.

Functional deficits. For instance a person without social skills may dominate the discussion. Psychotropic medication can also cause slowness and inability to stay alert in class.

Stress associated to going to school can be a challenge for most students.

Hospitalizations can be difficult and disruptive.

Systems management can be difficult. People had trouble with social security, VA and other systems. Now they have the college or university system.

Negative attitudes and stigma. Many times the message is "If you want to stay out of the hospital, you should participate in less stressful environments."

Negative attitudes and misconceptions are held by many people-the faculty, administrators, and staff.

There are many supports and resources which are built into place which can help keep a person employed.

HISTORY OF SUPPORTED EDUCATION MODEL
Karen Unger and the Center for Psychiatric Rehabilitation started around 1981. People were able to learn and teach more adaptive behaviors needed to live and work in more normalized settings.

The first work with supported education came from the clubhouses and the ability to try to get people into high school.

DEFINITION AND MODELS OF SUPPORTED EDUCATION
Education is integrated in integrated settings for people with severe psychiatric disabilities.

1. Self contained classroom
2. The on-site support model
3. The mobile support model

UNGERS THREE MODELS OF SUPPORTED EDUCATION

1.Self contained model the students have a prescribed curriculum.

Boston University Center for Psychiatric Rehabilitation and Thresholds offers onsite college preparatory courses. While not integrated into the community this program is very effective at preparing people for college and university.

2.On site model assists students on the college campus and helps them access resources that already exist. Disabled student counseling services and a variety of other support services which are provided on campus. The student may need support but the school is not given specific diagnosis.

3.Mobile support model follows the student on the campus and helps the student integrate in the life of the school. Laurel house in Stamford, Connecticut is an example of this.

3a.Group model is similar to this except there are groups which are established on campus and which can help with keep the the students engaged and helping each other. There can be some staff involvement with this.

OTHER MODELS OF SUPPORTED EDUCATION

1. Full clubhouse model
2. Partial hospital model
3. On site model
4. Freestanding model

Full clubhouse model has a supported education unit in the clubhouse.

Partial clubhouse model means that this is not full time in the club house. A staff person may come in once a week and help with education.

On site model is where a psychiatric service center can have an office on the campus. This office can be located at the disability services office. They might have a weekly support group. There should be at least one staff person who is familiar with working with people who have a psychiatric disability.

Free standing model is where an agency has an office on the campus. The free standing model can offer both supported education and vocational opportunities.

There might be peer support or there can be tutoring classes. The Michigan model offers people a variety of services. Including support meetings, academic support, and classes which help the student hone their study skills.

Choose, Get, Keep Framework

Choose phase is looking at catalog and trying to understand what different schools offer.

Get phase is helping the person find a specific school, registrar and apply for assistance

Keep phase focuses on the person staying in school and getting the help that they need to develop time and task management, maintaining concentration, taking notes and asking for assistance.

There are also natural supports, like establishing relationships with people and attending programs at the service centers. Some Supported Education can help people who are enrolled together can network and support each other.

Applying Psychiatric Rehabilitation Principles to Supported Education

Self determination-The educational goals, learning environments, and supports are selected by the student.

Individualization-The supports and services provided are designed to meet the unique needs of each student.

Normalization-These services are integrated and consistent with the routines of the setting.

Ongoing support-Support is available indefinitely and flexible to match the changing moods of the student.

Dignity-Supports and services are provided in a manner that protects the privacy and dignity of the individual.

Hope-There is obvious belief in the capability of the individual to grow and achieve academic and vocational goals.

Normalization
Conduct comprehensive individualized assessments
Utilizes campus program for some of the services
Services are utilized which protect personal dignity and cultural diversity
Services are evaluated on an ongoing manner to keep them responsive to students

Self determination
Provide knowledge of post secondary education Skill training and practice to survive
Assist students to set up their own educational goals and objectives
Choice is essential in the course of teaching strategies and learning topics
Support and Relationships
Invest in staff resources to outreach and engagement of participants in supported education.
Continuing availability which can be assessed as needed
Establish individualized and personalized relationships with students
Students are encouraged, given skills or assistance their own support networks which go beyond the supported education program.
Resources are available as needed to overcome personal barriers to educational involvement.

Hope and Recovery
Supported education emphasizes strengths, encourages possibilities fosters hope and promotes rehabilitation

Exclusion because of diagnosis is not appropriate
Supported education is based more on the recovery philosophy rather than treatment or clinical services

Involve students in all aspects of the operations, including paid staff positions so that modeling and examples of success are demonstrated.

Change the role of the person from mental patient to student. This is a change that is grand.

System Change
Incorporate person empowerment strategies, such as promoting and teaching self advocacy.
Promote group empowerment where the group advocates for each other as a group.
Maintains stakeholder environment and incorporates stakeholder involvement into their work.

Structure and mechanisms to address systemic barriers to full inclusion of students.

SUMMARY
Supported Education is a new and important development for people with psychiatric disability. The educational component can play an important part in a person's recovery.

CHAPTER ELEVEN
RESIDENTIAL SERVICES AND INDEPENDENT LIVING

INTRODUCTION
1. Why is it such a struggle for consumers to find a decent place to live in their communities?
2. Where did ex psychiatric patients go at the end of de institutionalization began?
3. What are the current models of residential service providers?
4. Can people with severe functional deficits live in regular housing in the community?
5. How can people with psychiatric disabilities achieve the goal of independence?

Before looking at the varieties of housing, the barriers of housing will be looked at. For years, transitional housing dominated the mental health field.

BARRIERS TO HOUSING
The two main barriers are affordability and discrimination

AFFORDABILITY
Increased housing costs have accelerated since 1999. The gentrification of inner cities has caused housing to become unaffordable. There are also cuts in federally assisted low income housing. There seems to be no affordable housing for people on social security money

STIGMA AND DISCRIMINATION
The stigma associated with people with mental illness results in housing discrimination. There is a Not In My Backyard Syndrome (NIMBY). Mental Illness equates with dangerousness.

Research suggests that success seems to depend more on characteristics of the community than the characteristics of the person.

Some people with mental illness have criminal records. The largest three mental health centers in the United States are LA Country Jail, Cook County Jail and Rikkers Island.

FEDERAL RESPONSE TO HOUSING DISCRIMINATION
In 1988, US Congress amended fair housing act to include people with disabilities. While there is good legal protection, many programs are delayed by community opposition.

WHOSE RESPONSIBILITY IS HOUSING?

The debate is between social welfare system and mental health system. The mental health system is seen as only providing temporary housing. This transitional housing is until someone gets placed in the community or community housing. However, most community housing is restrictive and does not provide consumers what they need.

Because of cost most of these residential services are available to a few people. From the social welfare position-public housing services are not prepared to provide services for people who are in great need.

Lack of housing means that people go back to live with their families or end up homeless or living with other people. They spend longer inpatient time at hospitals. Lack of discharge encourages passivity and increases dependency. Already scarce resources are made more scarce.

HISTORY OF RESIDENTIAL SERVICES

Several hundred thousand people were discharged in the 1950's to the 1970's. Where did they go? There was no clear plan. Many people went to live in boarding homes, nursing homes and the number of homeless people increased.

BOARDING HOMES AND SINGLE ROOM OCCUPANCY RESIDENCES

Around 300,000 to 400,000 people live in these places. These have grown. A person is rented a room and given some food. Boarding home owners are able to establish themselves as payees and take most of the person's check.

Many boarding homes are located in dangerous parts of town. Most people do not venture out to the neighborhoods because they are in crime ridden areas.

Access to psychiatric care for resident varies. These situations often mean sending people to day programs by the van load. These have become mini institutions.

FAMILY FOSTER CARE

The VA has used family care more than most people. 11,000 people were in foster care by the VA. This has advantages that the family helps the person adjust. This has it roots in Geel, Belgium. The person may function better at the home where there are children there. These programs provide a caring environment for people over a short period of time.

FAIRWEATHER LODGES

During the early days of deinstitutionalization, Fairweather Lodges were established by a person named George Fairweather. He came from the California VA. He set up groups where people discussed their discharge and how they would be responsible for other people who were also being discharged in their groups.

There was still recidivism. They set up a lodge program which was like a dormitory in the community. The initial lodge program was a success and these programs spread around the world.

1. Lodge members have meaningful roles in lodge and/or business. The members be given as much autonomy as possible.
2. Lodge members should have upward mobility with the lodge community
3. The role of the professional is that of consultant who bases his or her involvement on the current needs of the members.

Some members decided that they wanted to work in the community and not in Lodge businesses. This also meant that some lodges had to change to accommodate the full time workers.

Fairweather Lodges decreased in popularity because of decrease in state hospital admissions.

There are still 90 lodges operating in the community with 16 states. (http://theccl.org/Fairweather.htm)

National Industries for Severely Handicapped (NISH) was established. This was an organization which over saw set aside federal contracts for people with disabilities in business.

The fair housing act of 1988 meant that people did not have to live together to show stability with their housing. This law also decreased Fairweather Lodges.

RESIDENTIAL TREATMENT FACILITIES

While the boarding homes, SRO's and foster homes are typically non professional, the Residential Treatment Facilities are mainly professionally based. These programs are segregated, congregate care facilities. These facilities use a variety of different names group homes or half way houses. Most of these treatment houses try to establish a therapeutic milieu which tries to establish clinical and functional improvements.

Some of these programs have rehabilitation goals, striving to provide residents with independent living skills. Other programs focus on long term care in small home environment rather than an institutional setting.

3 to 5 individuals live in a home. Daily living skills are taught. There are community meetings, individual or group counseling, and symptom and medication education.

REHABILITATION TREATMENT FACILITIES AS RESIDENTIAL PROVIDERS
When a provider both rehabilitation and residential services, housing problems may follow if treatment recommendations are not followed. Sometimes links implicit but not articulated. Mize and colleagues suggest a collaborative approach to developing non coercive roles. Tenant and Consumer are different roles for the person receiving services. Landlord and worker are different roles for the person working in the agency. Mize and colleagues suggest that tenants must chose to live together, set their own rules and help one another be accountable for their actions.

STIGMA AND RESIDENTIAL TREATMENT PROGRAMS

Many residential programs are located in urban areas. There is a lot of prejudice which prevents people from having full community integration.

This article appeared in Boston Globe:

GROUP HOME INFLAMES NEIGHBORS

By Danielle Dreilinger

In cartoons, a bucket of water can calm a heated dispute. In Somerville's Winter Hill section, people are hoping a sprinkler system will cool down friction between neighbors and the residents of a mental health group home - friction that reached fever pitch after an Aug. 19 fire.

The Vinfen Corporation, a nonprofit human-services organization based in Cambridge, opened the home on Central Street in 1992. According to spokeswoman Donna Rheaume, Vinfen operates 61 psychiatric rehabilitation homes in the Boston area, five in Somerville. The fire started in a first-floor bathroom; according to Rheaume, residents moved temporarily to nearby Bartlett Street a month later.
But way before the fire, the home's Central Street neighbors were fuming over noise and alleged lax management.
Though Vinfen said it teaches life skills to the home's residents, it seemed like "smoking is their sole activity," said Molly Van Nice, 63, a neighbor.
When she went late at night to fetch her cat, Dave, who was buddies with the Vinfen residents, Van Nice said, "very often, I know for a fact, there was one person in the office."
The Vinfen residents were also often disruptive, she said, throwing bottles into a neighbor's yard and yelling. In one case, what a resident yelled was "Tell the neighbors to go to hell," said Van Nice.
According to Somerville police records, there had been 29 calls to 911 from the Central Street location last year before the August fire prompted its closing. Reasons included

illness and temporarily committing someone to a hospital, plus some accidental calls. November and last month saw 22 calls from the temporary home on Bartlett Street.
The neighbors say they aren't NIMBY types. "This isn't a witch hunt after the mentally ill," said Dyan Blewett, 54. She was concerned, she said, "that the residents weren't being taken care of."
Moe Armstrong, who directed recovery programs at Vinfen until about a year ago, said he had often visited the Central Street residence and thought the agency managed it well. He commended the level of staff training in psychiatric rehabilitation.
He said he thinks the general public doesn't understand how psychiatric rehabilitation works. What looked like inactivity to outsiders, he said, was in fact people "continually being taught and developed. How to prepare meals . . . look for a job, do shopping, get around."
Improvements take time, though. "It's easier to heal a broken arm than a broken mind," Armstrong said. The agency's clients spend an average of three to four years in the Central Street home, he said.
Vinfen spokeswoman Rheaume said there were "two awake overnight staff in the home at all times," plus three to four staffers during the day. The state Department of Mental Health inspects and licenses the facility.
Somerville Fire Chief Kevin Kelleher said that at the time of the fire, 6 a.m., one staff person was in the house.
Kelleher said the fire was caused by an electrical problem, not anything residents did.
Alderman at Large William A. White Jr. chaired a meeting of his board's Public Health and Public Safety Committee on Nov. 24 to address complaints about the group home. Vinfen officials attended, as did state Representative Denise Provost. Provost and state Senator Pat Jehlen later met with Vinfen and the Department of Public Health, Jehlen said in an e-mail.
As a result of the meeting, Vinfen agreed to install a sprinkler system - which is not legally required, Rheaume said - and meet with the Central Street people. "We want to be good neighbors and keep lines of communication open," she said.
The Central Street home is set to reopen in March with eight long-term and four short-term residents.
The fire sprinklers will ease neighbors' minds somewhat.
Richard Blewett, 57, called the safety improvement "a source of great relief."
Firefighters had responded quickly to the August fire, he said, but the building next door is only 4 feet, 9 inches away.
Still, concerns persisted. "As happy as we are about the sprinkler system, it really doesn't tell us what Vinfen is going to do going forward," said Jane Carey, 62. "Are they really going to take care of the people?"
White said he thought the Somerville contingent had made it clear to Vinfen that if complaints continued, officials would take them to the state licensing agency.
On a local level, "We have a noise ordinance," White said. "The city can start writing tickets." The committee requested the police to keep an eye on the Bartlett Street facility.
All hoped further intervention would not be needed.
"Everyone wants this to work," Richard Blewett said.
"With luck, things will start over and we can get off on a different foot."

This article leaves some questions unanswered: How does Vinfen explain the fact that there was only one staff member in the house at the time of the fire? What type of electrical problem occurred and how preventable was it? How solid is this facility's/ Vinfen's record according to the Dept of Mental Health? How expensive were the 911 calls? How do the residents of the facility feel about all this?
by BarryRafkind January 24, 10:34 PM

Thank you. These are questions and discussions which need to take place. There is a balance. Everybody needs to grow and change. Vinfen, the neighbors, the politicians need to think anew and differently. Psychiatric Rehabilitation can and does work. It does not work in vacuum. Requires work by all parties and permission to participate by all parties involved. This is not just psychiatric rehabilitation-this is real and good democracy, also.
by MoeArmstrong January 19, 7:53 AM

People who place houses should also be sensitive to the community. In some case neighbors cite practical concerns like parking.

There are also many communities where group homes exist together without friction. One study also found that neighbors sited benefits about learning disability issues.

EMERGENCE OF LINEAR CONTINUUM PARADIGM
This continuum was established to show the steps in transition to independent living.

What is offered in the residential continuum varies as do the names.

1. Several residential settings are available that offer different levels of service, provisions, staff supervision and less restrictive level.
2. Program participants are expected to move from more restrictive to less restrictive level.
3. Participants in each setting are similar in terms of clinical stability and functional ability.
4. If a program participant de compensates and returns to the hospital, he or she often re enters the continuum at the most restrictive level. (He or she has to start all over again at the bottom)
5. The ultimate goal is to go on toward independent living.

The literature suggest that this linear continuum approach has flaws. Changes in the living arrangement for people can be very stressful. With linear continuum, people have less access to program supports when and as they need them. It is not uncommon for people to have a crisis after they have their own apartment because they need more

supports. Also, it hard to generalize that because people learned living skills in one setting means that they will transfer those skills to another setting. There is also the question of housemates. When given their own choices most people would rather live on their own.
Many transitional living falls short on what PsyR believes: Community Integration and improved quality of life.

SUPPORTED HOUSING: A BETTER APPROACH TO RESIDENTIAL SERVICES

1. The rehabilitation approach avoids the notion of placement in favor of choice
2. Rehabilitation oriented services seek to expand consumer control, minimize rules, and external structuring, and maximize consumer responsibility for day to day problems and promoting mutual support, self help and consumer operated services.
3. Many consumers(participants in programs) live with family members or choose to have them involved. Family members need to be involved in the rehabilitation approach with support and information.
4. Normalization, a guiding principle of PsyR, a normal living environment which which is perhaps the most important environment in our lives. Normalization also means recovery, creation, and maintenance of valued social roles, such and neighbor, tenant, and room mate, as opposed to group home or supervised apartment resident.
5. People with disabilities may need assistance in developing ADL skills. Skills development happens best when there is a specific environment. Skills development might not be the same for some living in transitional living and someone living independently.
6. Supports, both formal and informal, must be available and responsive to changing needs. Informal or formal supports include family members, neighbors, friends, peers, and other people in the community.
7. All needed supports should be flexible, individualized, and available as long as the individual needs them.
8. Advocacy is greatly needed to combat stigma, community resistance and the lack of decent and affordable housing.

The 1990's saw the opportunity for supported housing.

What are those supports:
1. Staff available by phone 24 hours/seven days a week.
2. Financial resources
3. Help in budgeting money
4. House furnishings and supply

IMPLEMENTING SUPPORTED HOUSING APPROACH
What needs to be changed from the Continuum approach to supported housing.
There needs to be a change of staff attitudes and skills. Staff members who work in supported housing programs teach skills to consumers in their homes and assist people in requiring resources. They new staff need to flexible to be effective. Consumers take much more control over the services that they receive. A number of supported housing

programs have employed consumers in providing services. Using consumers as staff has the ability to empathize with people in the programs. Peer providers have also been more able to access and know about resources in the community. Consumer providers can also better attuned to what people in the programs to attain independent living.

What are the challenges:
1. Accessing housing which matches consumer preferences
2. Helping people acquire rental or mortgage assistance
3. Financing individual support services

Entitlements such as Social Security and other benefits are not enough to help the person get housing.

Some people used money that was to go into building new hospitals-was redirected in building affordable housing. This was done in Ohio.

Other states states have increased access to public housing.

New Jersey set up Housing Trust Funds for affordable housing.

OUTCOMES OF SUPPORTED HOUSING APPROACH
Three studies by Dickey and Goldfinger suggests that housing increases by providing supports rather than specific program model.

Sam Tsemberis also found that supports added to ACT teams nearly doubled the housing stability compared to typical residential treatment.

INDEPENDENT LIVING MOVEMENT
Housing for people with psychiatric conditions takes a lead from the independent living movement for people with physical disabilities.

1. Recognize that it is not something internal which keeps people from living independently. The external barriers keep people from going where they want to go and do what they want to do.
2. People with disabilities have the right to make choice and take risks.
3. People with disabilities become become experts in their own self care.

Boston University with Mary Ann Farkas and Judi Chamberlain have done work applying these concepts to people with a psychiatric disability. They taught consumers to train, hire, manage personal care assistants with people with people who have psychiatric disabilities.

HOUSING FIRST

People are placed into housing first. Like with supported employment people are placed first and then given the services to keep them in housing. People do not have to be clean and sober first. Housing is obtained first.

This method was tested by Sam Tsembaris and found that people without prerequisites and proper supports maintained their housing longer. People without prerequisites did have higher utilization of substance abuse services. People did respond well to harm reduction model. Consumers are allowed to use alcohol or not and not be adversely affected. Their housing is not threatened. Help continues to be available to them.

SUMMARY

From the mid 1800's until the 1060's most people who had a mental illness lived a good part of their lives in institutions. Since deinstitutionalization the question most asked is where should consumers live?

Many people were left the institutions. They had no place to live. The were placed in nursing homes, boarding homes, SRO's. Most housing options were called trans-institutionalization. In the 1980's, the model of care was the linear continuum. The graduation of this was independent living without any support. The field of PsyR now supports a model called supported housing. This approach seeks to support consumers in the home environments of their choice. Supported Housing supports long term housing options. The supported housing model is similar to the Independent Living Model for people with physical disabilities.

PsyR practitioners do not provide treatment which is provided elsewhere in the system. Nor do they provide supervision which is not wanted or needed by people with psychiatric disabilities. Supported housing assists consumers in developing skills and obtaining the resources that people need. Supported housing is similar to supported education and supported employment.

Housing First model suggests that attending to the basic desire for a safe place to live is consistent with the values of PsyR, such as self determination and respect for dignity and worth of the individual. Given the complexities of housing, individualized services should be the rule and not the exception.

Despite the barriers, such as stigma, community opposition, and lack of access to community resources, supported housing brings real hope to consumers who want to live, work, and socialize the same way non disabled members carry out their lives.

CHAPTER TWELVE
CONSUMERS AS ADVOCATES AND PROVIDERS OF SUPPORTS AND SERVICES

INTRODUCTION
1. How have self help groups impacted PsyR
2. What services are consumers capable of providing?
3. What are some of the issues around having consumers also provide services?
4. Should consumer provider disclose his/her condition to other professionals?
5. What are some of the benefits and concerns around consumers providing services?

Consumers are moving into service provider field. The problems that people face are both immense and exciting.

HISTORY OF SELF HELP AND EX PATIENT MOVEMENT
Back in the 1940's there were ex psychiatric patient's who described themselves as WANA(We Are Not Alone). They began as a self help movement and eventually became The Fountain House. Today the self help movement plays and important part in the treatment, support and public advocacy for people with a severe and persistent mental illness.

Self-help is an attempt by people with mutual problems(conditions) to take control over circumstances in their lives. Found on the principle that people who share a disability that professionals can not provide, self-help efforts take many forms. (Segal, Silverman, & Temkin, 1993. p. 705)

Dr Abraham Low, who was a psychiatrist, developed a treatment that was similar to what we call cognitive behavioral therapy. In 1952, he founded Recovery, Inc. His methods are outlined in the book Mental Health Through Will Training.

Alcoholics Anonymous was founded in 1935. Recovery, Inc. has grown into an international organization totally run by its members. They share their stories in four steps

1. Members summarized situations that trigger their distress
2. Members specify symptoms that they experienced
3. Third step requires labeling symptoms using Recovery Inc. terminology
This is so members can reframe the experience into manageable aspects of day to day functioning.

4.The last step requires that members speculate how they would have handled the situation before they learned the self help techniques.

Recovery, Inc. still is an important aspect of the self help movement. There are people who do not understand it or believe in it.

Also, the Civil Rights movement of the sixties gave rise to the consumer movement and empowerment. Through antiquated commitment laws, the consumer movement grew. Also, many people released found that the programs on the outside did not meet their needs.

By the early 1970's, an ex patient movement, sometimes called the survivor movement, was started. Some of these names were Mental Patient Liberation Front, the Alliance for the Liberation of Mental Patients, and the Network Against Psychiatric Assault. These groups started with advocacy and then moved into offering alternative services.

Some self help groups started in conjunction with existing mental health services. An example might be a group of consumers who attend a day program and might want to start their own self help group.

However, some people involved in the ex patient movement maintain that separation is essential. Judi Chamberlain wrote the book On Our Own which believes that only outside the mental health system can self help groups flourish.

1974 was when the book, Your Rights As A Mental Patient In Massachusetts, was published. Other groups have led to the development of Drop In Centers and other services which are outside the mental health system. Consumer run services have gained in momentum and credibility.

SELF HELP GROUPS/ INITIATIVES TODAY

Today self help or mutual help initiatives are part of the mental health systems all across the country. For some people, self help is still an alternative to the mental health system.

CONSUMER PROVIDER COLLABORATION

Psych Rehab Practitioners are motivated to have self help and peer support services for two reasons:
1.A good practitioner recognized that supports outside the mental health system is essential to the recovery process.
2. Good practitioners and administrators see these services as cost effective ways to provide clients with additional supports during an era of dwindling dollars.

From National Self Help Clearing House

Consumer run services are perfectly positioned to fill the service gap resulting from state and local cost control measures such as managed care if consumers are educated and supported in their efforts to expand existing consumer run projects, launch new ones and test new models (Rogers, 1996 p. 22)

There can be resistance
-Lack of information about key self help initiatives
-Understanding the ability of consumers as service providers
-Negative reactions to efforts associated with the ex patient movement, such as worries about rebellion or eventual non compliance with medication.

There is a five stage process to have consumer initiatives introduced and take hold in the mental health system.

1.In the investment/ nuturance stage, the staff promotes increases social interaction between members of the program. Members become more involved in the well being of their peers.
2.In the initiative/ delegation stage, consumer assume greater responsibility in planning program activities. Some members begin to emerge as leaders. Staff members support these changes by delegating some of their responsibilities and teaching/modeling leadership skills.
3. During the Rebellion/Dialog stage, member openly express dissatisfaction with both their role as patient or client and the control exerted by the mental health system. Staff promote human rights and recognize the validity of their concerns. During this phase, the staff work to develop the self help initiative. Staff work toward reducing administrative resistance to the initiative and provide consumers with information about access to information about self help groups.
4.In the accommodation/ collaboration stage, consumers deal with role shift issues and may begin to adopt new labels. Staff members can serve as important members resources during this period of transition.
5.In the self help/consultation phase, consumers establish formal self help initiative. Staff members provide an as needed consultation role.

SELF HELP AND MICA

People dealing with both mental health and substance abuse issues are more likely to get referred to a self help group. Some of these groups are AA or NA. Some of these groups are based on the idea that this is double trouble. In some areas staff presence has been permitted at these groups. Double trouble support meetings emphasize two concepts
1. Acceptance of the importance of psychiatric medication.
2. High tolerance of psychiatric symptomatology.

Staff have been involved in the implementation of peer support services on in patient settings. Some people have not accepted self help groups. Acceptance may be based on the stage of recovery. Consumers with MICA diagnosis seem to do better in later stages of development.

SELF HELP AS ALTERNATIVE TO PROFESSIONAL SERVICES

By the early 1980's people with psychiatric conditions began to receive better credibility through conference presentations. Obtaining funding was a point of contention with some ex patients people thought that they were being co opted by money.

There are people who continue to advocate for people and people's rights like the National Empowerment Center in Lowell, Massachusetts. The NEC provides a variety of information about recovery and empowerment in the form of publications, training materials and speaker's bureau.

A study by Chamberlain reviewed 64 self help programs. People who attended these programs were very involved spending 15.3 hours a week at these self help centers.

CSPNJ is a good example of a consumer run agency which delivers peer supported services.

New Jersey has twenty three drop in centers.

CONSUMERS AS PSYR PROFESSIONALS

In a wide ranging way consumers are being hired as mental health workers

1. It is important with a rehabilitation philosophy, that productive and important work is made available and accessible to consumers
2. Inclusion of consumers as mental health workers can increase the sensitivity of programs and services about recipients.
3. Consumers can service as effective models for other clients
4. The inclusion of consumers is an expression of affirmative action and consistent with contemporary civil rights issues. Carol Mowbray

Prosumers is another name given to people with mental illness who work in the mental health field.

EFFICACY OF CONSUMER-PROVIDERS

From the beginning substance abuse has organized consumers into peer support positions. Consumers can truly empathize with others. Consumer providers have an

advantage in the length of time that it takes to establish a trusting relation with service recipients.

The field of mental health has been slow to recognize the these benefits.

Perhaps there is greater stigma to having a mental illness than a substance abuse.

Consumer Provider seem more credible on medication issues, especially when they use their own experiences.

The mere presence sets a tone for the program that there are valued social roles as consumer providers.

Consumer providers on ACT teams or MHICM Teams have proven to be a valuable resource. They have understood what people receiving the services are going through and have been good advocates.

The impact of hiring consumer providers has not been widely studied. Initial research has shown that consumer providers are favorable in comparison to other workers.

Recommendations for future study of Consumer Providers includes utilization of participatory action research approach so that Consumer Providers have a voice in participating their contribution to the psych rehab field.

CHALLENGES FOR CONSUMER PROVIDERS

one of the challenges is that Consumer Providers generalize their lives to be like the people who they work with. They can fail to understand the diversity of experience of the people who they work with.

Another drawback is the maintenance of confidentiality. Consumer providers, especially if working in the agency where they got services, may struggle with boundaries.

Because mental illness is stress related, many consumer-providers, and their employers , have concerns about coping with the high stress from Psych Rehab provision of services.
Will they be more prone to burnout?
Will they need to take an lengthy sick leave?
Can they get back on benefits if they need them?

Some people who receive services are also concerned about receiving services from someone who has mental illness. Consumers can be both victims and perpetuators of stigma.

RELATIONSHIP WITH NON CONSUMER PROVIDERS

There can also be difficulties from not being accepted by the people who work in the system. People are afraid that their behavior will be analyzed. Consumer Providers can be seen as too angry or too sad or too emotional. Their co workers might feel that they need to counsel the Consumer Providers.

Happily, negative treatment of Consumer Providers is not always the case. Many report positive relationships with co workers.

DISCLOSURE

This is a dilemma for people who were hired as mental health workers and these positions were not specifically as Consumer Providers. People struggle about to disclose or not to disclose. Pat Deegan and others feels that the mental health workers who do not choose to disclose loose a part of the effectiveness with the people in the programs.

Disclosure is left to the Consumer Provider and should never be required.

NEEDED SUPPORTS AND EDUCATION TRAINING

Strong and appropriate supervision is required for consumer providers who are dealing with both standard issues around professional growth and development and the unique challenges.

Supervisors who are working with Consumer Providers will also need special training and room in their day to provide extra time with Consumer Providers.

Consumer Provider support meetings outside the agency also help air feelings and concerns which they may not want to share in the agency.

It is likely that Consumer Providers who move into more normalized professional roles will be in less second class roles. They will less likely be segregated from other staff and will not have to struggle with role definition issues.

There are some Consumer Providers who come into the work place with degrees. There are some who do not. Some professional degree programs have shown a bias against admitting consumers in their academic program.

It is important to distinguish between integrated degree programs and training programs. Training programs can put consumers in second class roles.

OTHER INFLUENTIAL ROLES FOR CONSUMERS

In addition to working in a variety of provider roles, Consumers can also be on governing roles or administrative positions inside state departments of mental health.

Increasingly Consumers are also contributing ways to program evaluation and research studies.

PsyR Professional organization are another important place to have consumer involvement. Any interaction between consumers and professionals can have a positive influence. Ten years ago professional conferences were a chance for professionals to talk with each other, now these conferences are an opportunity for consumers and professionals to share ideas.

SUMMARY

Peer Support is an important part of the community support systems.

Peer support can be an alternative or part of the mental health system.

Peer Support can also be given by professionally trained providers who have experienced mental illness. Psychiatric rehabilitation must learn to work with a variety of consumer mental health providers. There are consumer providers, activists and policy makers. This also means respecting the choice of consumers who use self help groups and alternative programs. This means respecting the choice of consumer providers who are in and outside the system.

CHAPTER THIRTEEN

THE ROLE OF FAMILY IN PSYCHIATRIC REHABILITATION

INTRODUCTION

The catastrophe of mental illness strikes not only individuals but also the families. Many of the first community mental health programs were designed for single people who were de institutionalized and had no families.

Today when long term hospitalization is the exception rather than the norm, families are the providers of care. Today more people are likely to stay in contact with their families. Today people with mental illness are likely to also be married.

In the past the families were seen as the cause of mental illness and not the care givers. An environment of over involvement might contribute to relapse in some cases. This highly charged environment is called high in Expressed Emotion.

An environment high in Expressed Emotion can also be found in other places, like residential settings or some clinics.

Families were once seen as dysfunctional and are now seen as resilient and resourceful.

Family members are seen as being able to make a contribution to the person's recovery.

Good family involvement can greatly reduce recidivism. This family involvement is based on illness education, support, problem solving, and crisis interventions.

FAMILY WORK AND PSYCHIATRIC REHABILITATION

Like the rest of society, mental health professionals have let fear and blame dominate their interaction with families.

In particular, psycho education of consumers and families can ensure reasonable expectations of the disease, its treatment, and rehabilitation.

Thus, it probably best that families are involved in the long term process of Psychiatric Rehabilitation.

THE FAMILY AS "CARING AGENT"

Today the family has become the care givers. Half of people return to their families after hospitalization. Among short stay persons, as many as four out of five return to their families.

Families must deal with both the positive and negative symptoms, but the negative symptoms seem to be hardest on the families.

Impaired level of functioning, relates to loss of old skills and failure to acquire new ones. This cause more dependence in the home and causes the person in care to need more care.

DUAL DIAGNOSIS AND THE FAMILY

When a person has a developmental disability or substance abuse condition mixed with the mental illness the whole situation becomes compounded. The families seem to be become overly involved and or completely shut off.

The families will have spent a great deal of resources. For instance, they will have spent money on rent and the person spends money on getting high.

Families can have built in sophisticated coping skills with the family.

INDEPENDENCE VS DEPENDENCE

The balance between these two states is a debate. For many adults, dependence on many others is a virtual necessity.

It has been found that any adult child continuing to live with the parent causes a stressful situation.

BURDEN AND STIGMA

There is a family burden by having the person continue to live in the house. There is also the stigma. Many times the families are seen as the cause of relapse.

Mental health professionals may be contributing to this by attitudes that reinforce the idea of crazy making families.

Family members feel other people are avoiding them.

Many family members feel that their burden is very sad, draining and lonely.

THE OBJECTIVE BURDEN

Objective burden can be financial hardships, the cost of consumer's economic dependence, disruptions in household functioning, restriction of social activities, and altered relationships because of care giving.

THE SUBJECTIVE BURDEN
Subjective is the psychological stress of the person living in the home. Families have periodic crisis with emergency services and the police. This is psychologically stressful.

TROUBLESOME ACTIONS THAT CONTINUE TO BURDEN
-Hostile, abusive or assaultive behaviors
-Mood swings, other unpredictable behaviors
-Socially offensive or embarrassing behaviors
-Poor motivation seen as malingering
-Apparently self destructive behaviors, such as poor handling of money

Thinking about what happens after the care giving parents die.

Just having normal expectations can lead to difficulties because the person might not be able to fulfill these only normal expectations.

Today the psycho education programs for the families go a long way to stabilizing the person's psychiatric condition and lead to independence.

FAMILY DISSATISFACTION
Given the situations that families have to deal with the mental health system should be responsive to their needs. This is not so. Families express dis satisfaction with the mental health system and mental health professionals.

For instance, sometimes professionals withheld important information which could have helped with the person's at home care.

Sometimes the family members seem like they are getting mixed messages. The family member is told that they are over protective and then told that they are too risky. If the family member does not take the advices of the professional then the family member is seen as sabotaging treatment.

Too often professionals have been disapproving in the messages that they send family members.

Given these communication problems, family members have become alienated and resentful.

THREE LEVELS OF FAMILY INVOLVEMENT

1. The immediate family. Those most likely involved with the individual directly.
2. The family involved in the ups and down but not directly involved in the day to day life
3. The relatives not in the immediate household but share a common interest of the consumer.

There are professionals who are family members. Their subjective and psychological(objective) burden did not differ much. Like other family members they assigned a high priority to education of symptoms, and medications and techniques for managing difficult behavior. They believed in support meetings. The also were afraid to talk much about their own lives since they had heard colleagues make negative or otherwise disparaging remarks about other people with mental illness.

THE UNIQUE BURDENS OF SPOUSES

An estimate of 35 to 40% of people discharged from hospitals are discharged from their homes to live with their spouses.

-Martial dissatisfaction and disruption
-Financial problems
-Socialization difficulties
-Personal experiences of emotional and mood symptoms
-Separation and divorce

Clearly when one's spouse has a major mental illness, this puts a great deal of stress on the relationship.

SIBLINGS AND CHILDREN

The brothers and children can feel that the emotional needs and responses in the family have revolved around the sick one.

-Absence of normal development
-Difficulty determining which experiences were normal and which were not
-Altered role, such as parentification (a child having to care for a sick parent)
-Their mental health conditions
-Strains in relationships outside of family
-Fear of developing mental illness themselves

PEOPLE WITH MENTAL ILLNESS AS PARENTS

Parents with mental illness face the same challenges as other people with mental illness and.....poverty and social isolation. Also, their children do not feel part of society around. They are poor and neglected and outcast.

Those who began mental illness well after mother hood had the best adaption.
Second, were those that mental illness after the birth of their children
The worst, were mothers who experienced mental illness with the birth of their children

Single mothers face more financial strain and health problems. More of these problems than people who are just poor. There are a vast majority of men who have mental illness and want to be involved with their children.

1. Development of natural supports for parent and child. Parents need to make the effort to integrate their children more outside the home. Children can benefit from supports of family, friends, classmates and participation in school.
Parents need to learn how to involve a child in supports outside the home
2. Parenting skills can be learned and these skills are complex cognitive and emotional tasks. There are several parenting skills for parents of children with Attention Deficit Disorders.
3. The necessity of relapse plan is important to have in case the person at any time has a relapse. This is to protect the family, the home and the job.
4. Normal interests outside the home. Both, the child and the parent need these normal interests outside the home
5. Awareness of legal rights. There if often a great deal of pressure to relinquish custody. Sometimes, open adoption is an option.
6. Professional supports Maintaining regular contact with mental health professionals is important.
7. Age-appropriate education regarding mental illness Children should be educated with information that they can understand. With this information, the children can help the parents manage the symptoms during their lives.

Contrary to popular belief the children of people with mental illness do not have mental illness themselves. Through education, stigma can be avoided and the child can grow up with knowledge of mental illness and not have this condition.

Being a parent is a normal adult role which some people with mental illness might want to pursue. Like other roles,

THE ANGUISH OF THE INDIVIDUAL

People come to grips that they might have to take care of the person their whole lives. Some the loss they might encounter in their personal lives such a impoverished life. What they will or have missed out on.

This means that the person living with mental illness has extended grieving, and so do the relatives. There is a loss of personality, skills and strengths of the person living with the mental illness.

THE BURDENS OF FAMILY LIVING FOR THE PERSON WITH MENTAL ILLNESS

People who lived in environments of Expressed Emotionality (EE) were more likely to relapse. This Expressed Emotionality is show by environments of hostility, criticism, and levels of emotional involvement.

A climate of Expressed Emotionality contribute to on set of psychosis.

THE DILEMMA OF FUNCTIONAL EXPECTANCY AND INDEPENDENCE/ DEPENDENCE

These are two states which can create dilemma. How much can the person do. How much do the need care. How much can they be independent. These stress are felt more in a family environment that solitary living.

LONELINESS

One of the most common complaints about people with mental illness is their persistent loneliness.

GOALS FOR HELPING FAMILIES

-Establish a working relationship with the family in which there is a genuine working alliance which is a partnership in order to help the consumer.
-Attempt to comprehend familial problems that might be contributing to the stress levels of the consumer and family member.
-Gain an understanding of the family's resources and what is successful and unsuccessful.
-Build rehabilitative endeavors around the families strengths
-Develop appropriate expectations for the rehabilitative and treatment process through a contract that includes specific goals which are both mutual and attainable.

FAMILY INTERVENTION

These are common principles which are shared in all family interventions
-Schizophrenia and other major mental illnesses are regarded as medical, biological conditions.
-The family environment is not seen as the etiological(causing) environment
-Social and emotional support is provided, often including support from other families.
-Routine psychotropic medication management is included as an essential

These are some common components of educational intervention
-Psych education Information about mental illness, similar to what was studied in the first three chapters.
-Behavioral problem solving Structured problem solving about daily issues, crisis, and so forth. Begin with brain storming and move to specific problem solving.
-Family support Empathy from other families and families regarding the plight of the families.

-Crisis management Concrete information on the de escalation of crisis, coping with increase in symptoms and so forth.

Some courses have many more components.
-Definitions of the diagnosis such as schizophrenia
-History and prevalence of the disorder
-The role of biology of the disorder
-The role of psychotic medications, how they work, impact on outcome, therapeutic value and side effects.
-Psycho social treatments
-Course of the treatment and impact of illness on treatment course.
-Impact on family
-Familial response
-Common problems families face
-Strategies for family coping including revising expectations, avoiding over stimulation, selectively ignoring certain behaviors, setting expectations, identifying signals of impending trouble, effectively using professionals

These are soome courses teach the family how to build a supportive environment

SUMMARY OF EMPIRICAL EVIDENCE
If psych education takes place in the family setting the outcomes are impressive.
If psych education combines different family groups together, the out come is even more impressive.

Being able to include the person who is receiving care in the family setting is even better in outcomes.

Family education also proved to be very effective with people who had high Expressed Emotionality (EE) in their family setting.

The effectiveness of three studies which showed that psycho education with multiple family groups was the most effective. Psycho dynamic therapy groups with multiple families had to be discontinued for ethical reasons because of high relapse.

THE EFFECTIVENESS OF FAMILY EDUCATION AND SUPPORT
1. Families should be offered family psycho education which lasts at least nine months
2. This education should include education about mental illness, support for family members, formal behavioral problem solving and crisis intervention skills.

MAIN BENEFITS OF FAMILY INTERVENTION
-Decreased risk of relapse and decreased number of day spent in hospital
-Reduction of tension in family life
-Significant reduction is hospital admissions
-Improved social functioning

-Improved employment outcomes
-More independent living

Also
-Improved families abilities to understand patient's needs
-Reduced burden felt by family care givers
-Quality of life significantly improved
-Decreased levels of over involvement and criticism.

FAMILY PSYCHO EDUCATION AS EBP

Critical ingredients
1. Mental illness education
2. Problem solving
3. Stress reduction
4. Long term duration
5. Family and consumer involvement

Outcomes of Family psycho education
1. Reduces relapse
2. Reduces hospitalizations
3. Improve family knowledge of mental illness, symptoms, medications, therapeutic effects and side effects.
4. May improve family problem solving
5. May reduce family stress
6. May assist family recovery

A variety of family educational strategies have been used. Family Psycho Education is an EBP

Mental illness education consists of providing family members with probable causes of mental illness. What to expect from treatment and also medications.
Problem solving skills are taught through role modeling. This helps build family morale and confidence.

Stress reduction is taught so that families can also be better care givers.
Long term duration mean that family education is given as long as it is wanted and needed.

Family and consume involvement means that the consumer is part of the family and integrated into the training.

Fewer relapses and fewer hospitalizations with family education.

Family Psycho Education still has not been widely incorporated into the mental health system.

OTHER FAMILY PSYCHO EDUCATION AND SUPPORT
PROFESSIONAL AND CONSUMER COLLABORATION

NAMI (The National Alliance on Mental Illness) also has a package called Family to Family. This model has been running longer with the most consistency.

There is also a model which is based on professional and consumer collaboration. This model starts off with professionals running the meetings and turning the meetings over to the group members.

THE CONCEPT OF FAMILY RECOVERY

STAGE 1:DISCOVERY/DENIAL
STAGE 2:RECOGNITION/ACCEPTANCE
STAGE 3:COPING AND COMPETENCE
STAGE 4:PERSONAL/POLITICAL ADVOCACY

THE STORY OF NAMI
Family members have always been care givers. NAMI (The National Alliance for The Mentally Ill) has tried to formalize that relationship.

NAMI was founded in 1979 in Madison, Wisconsin. The first meeting had about 250 people there. NAMI started to do outreach and incorporate other people and organizations into the singular non profit organization. By 1982, NAMI opened its doors in Washington, DC. NAMI is a grass roots, support and advocacy organization of families and friends with mental illness and those person themselves.

NAMI has focused on the unfulfilled needs of the persons with most serious forms of mental illness. Many are parents who were blamed for their children's mental illness. They have experienced stigma first hand.

NAMI families join together to advocate for both needed changes in public policy and public attitudes. NAMI members have been supportive of research into demonstrating the biological basis of what NAMI calls brain diseases.

NAMI's focus is on brain disorders or serious mental illness

NAMI has approximately 140,000 members and 1,100 state, county and local members.

NAMI is dedicated to the eradication of mental illness and to the improvements of the quality of life of all whose lives are affected by those diseases. NAMI mission statement.

NAMI has helped to support and promote ACT teams.
NAMI has also helped promote involuntary out patient commitment.

FAMILIES HELPING EACH OTHER
-Learning about feelings, learning about facts
-Introduction to schizophrenia (didagnosis, crucial periods, etc)
-Introduction to depression
-Basics about the brain
-Problem solving skills workshop
-Medication Review
-What is it like to be mentally ill? (Empathy)
-Relative groups and self care
-Communication skills
-Rehabilitation
-Advocacy (fighting stigma)
-Certification and celebration

NAMI also has consumer programs In Our Own Voice and Connections.

FAMILIAL STRENGTHS AND RESILIENCE

There seems to be a large genetic component. Families also can have great resilience. How does that resilience play out. What can families learn from each other?

Family resilience needs to be studied. Families can do problem solving and help each other.

SUMMARY
If families can be engaged, they can become the most important partners in recovery.
Families did not become mentally ill.

CHAPTER FOURTEEN

PSYCHIATRIC REHABILITATION IN HOSPITAL SETTINGS

INTRODUCTION

1. Can the principles of psychiatric rehabilitation be applied in hospitals?
2. Are psychiatric hospitals and impediment or can they foster community integration?
3. Can recovery and quality of life be fostered by hospitalization experiences?
4. What are both the implications to both applications of PsyR principles and the pursuit of PsyR goals in hospitals?

Psychiatric hospitals around the world have been plagued by well documented abuses. There is strong evidence that psychiatric care is not being followed in these hospitals.

Many reformers have focused on improving the physical plant, reducing the size of the institutions, building smaller wards with private or semi private bedrooms, or reducing the buildings resemblance to a prison.

Can these institutions which are reported to have neglect and abuse based on iatrogenic effects of institutional behavior really change?

Experts disagree. E. Fuller Torrey thinks that shorter stays have contributed to lack of recovery. Also, he points out the lack of easy and fast access to hospitals can play a role. Patrick Corrigan thinks that hospitals can be one of the settings where successful rehabilitation interventions can be implemented. There is little daily living skills training in the hospital setting.

If hospital administrators adhere to Psych Rehab practices, is it possible to promote recovery?

1. What are some ideas that you would do to promote recovery?
2. How would you teach life skills in the hospital?

A 19TH CENTURY INSTITUTION IN THE 21ST CENTURY

The institutions are 19th Century institutions trying to adapt to the 21st Century. Many of these institutions where in rural or pastoral settings to bring peace of mind to those in turmoil. They are run by the government, including the VA. They came out the concern for neglect and inhumane treatment which came from people who neglected and put into poor houses for their psychiatric condition. These institutions for people with mental illness came about at the same time as large institutions to rehab criminals and

teaching practical skills to other people with disabilities. There was a sense of having the opportunity to do moral reform and succeed for those who were in prisons also.

Eastern State Psychiatric hospital was operated by the city of Williamsburg, Virginia

Mental health reform took place in the United States took place in the United States by Dorthea Dix. This was the government accepting larger responsibility for the mentally ill. Dorthea Dix lived a long time at Trenton, New Jersey. She died there and is buried at Mount Auburn Cemetery in Cambridge, Massachusetts.

COMPARISON AND CONTRASTS WITH TODAY'S HOSPITALS

The hospitals of the past bear little resemblance to the hospitals of the present. The hospitals of the past were self contained units mainly working farms with live stock and crops. Many people who worked with the "patients" also lived on the grounds. They maintained themselves through production of materials that were also manufactured

Milieu Therapy and Work ordered day came out of these environments. There was a strong belief that environment was treatment.

Greystone was founded in 1876. 43 buildings which housed 6,000 patients and about the same amount of staff.

From 1876 to 1943, the foundation of this Greystone hospital building was largest building to sit on a single foundation in the United States of America. That is how big these institutions were.

The hospital saw many new innovations introduced. Occupational therapy, small cottage residences organized around rehabilitation and anti psychotic medications were some of the innovations introduced at this hospital.

However, some procedures like psychiatric surgery proved to be harmful

In 2006, there are only 600 people in the hospital and about to be downsized to 250 people. Today, Greystone has one vocational program and contracts with other programs which provide vocational programs to the people who receive care at Greystone.

One of the greatest obstacles to having psychiatric rehab in hospitals is attitude. Many staff people who work in the hospitals do not believe that people who receive care in the hospitals can get better.

Many of the staff in the hospitals only see people at their worst. They infer that people are only at their worst at these times. Many people in the hospitals do not get to see people doing well and living in the community.

MANY MEANING OF "THE SHAME OF THE STATES"
For many years, the shame of the states remained the psychiatric hospitals. People have done little for mental health and people with mental illness over the years. Yet, the psychiatric hospitals have been rocked with scandals about inhumane conditions and lack of treatment.

The scandalous conditions which preceded deinstitutionalization continue today. Concerns about treatment have caused other states to curtail the number, size and census in their hospitals.

At the same time, the insufficient availability of hospital beds or alternate forms of providing acute and intermediate care has been equally shameful.

Care has gone from the state hospitals to prisons and jails. The three largest centers for housing people with mental illness are LA county jail, Cook County Jail and Rikers Island New York. 200,000 people with mental illness or more are incarcerated in jails in the United States. LA County Jail has 1,400 people with mental illness.

FUNCTIONS OF STATE HOSPITALS

State hospitals filled an important function for people with mental illness
Maintenance(providing for the physical needs)
Care(often long term)

1. Advent of psychotropic medications
2. Changes in US Social Security laws
3. Series of US Supreme Court decisions
A series of Supreme Court decisions Wyatt vs Stckney and Donaldson Vs O' Conner found that psychiatric hospitals often deprived people of their rights.

Psychiatric hospitals fill these functions
-Short stays(less than one month) for the management of acute symptoms
-Extended stay For some individuals longer stays are needed for stabilization
-Long stays For individuals who longer care and more supervision. The hospital provides both residential and case management services under one roof.

In addition there are these functions
-Forensic Care Hospitals serve a population of people who are under court order and have legal involvement. People with histories of sexual offenses are committed to jails and then released to hospitals because they are a danger to themselves or others.

-Geriatric Care

Most psychiatric hospitals provide care to most people who are court ordered
1. Individuals in acute phases of their condition
2. Individuals who are not responding to treatment for one reason or another
3. Person who are potentially harmful to themselves and others

Psychiatric hospitals are the last stop for many people in their stations of care

LENGTH OF STAY AND REHABILITATION OUTCOME
Evidence shows that neither very long or very short stays are good. Very long stays are seen to be part of the iatrogenic (effects caused by treatment). These effects that were talked about earlier. Extreme dependence and passivity. Short stays do not give people the opportunity to learn how to manage their symptoms.

The number of days which seemed the most effective were 11 to 25 days. 18 to 94 days in patient stays seemed to be less successful.

POPULATION SAVED BY STATE PSYCHIATRIC HOSPITALS
The people who are in our state hospitals are people who have been in the mental health system. They are known by all. They have also had exposure to PsyR Services.

CHALLENGES IN THE HOSPITAL ENVIRONMENT
Many large psychiatric institutions have been plagued by well documented reports of patient neglect or abuse and reports of deteriorating, unhealthy, unsanitary living condition. Also, there is a growing evidence that psychiatric care in those institutions is inadequate with even basic guidelines for the prescription of medications not being followed.

SECLUSION AND RESTRAINT: DEFINITELY NOT PSYCHIATRIC REHABILITATION

Restraints are used in hospital and in patient settings. Restraints are shown to have done no more than humiliate and exhaust the person. Often restraint took place when approaches had failed and sometimes the staff contributed to the escalation of the person's distress.

In some countries and some states, the use of seclusion and restraints have been completely eliminated.

Medication used solely for a sedative approach and not for psychiatric symptom management is another form of physical restraint.

BEYOND ELIMINATING RESTRAINTS: IS PSYCHIATRIC REHABILITATION POSSIBLE IN THE HOSPITAL SETTING?

The answers are in the following parts.

PSYCHIATRIC REHABILITATION GOALS

Recovery-Hospitals can provide the best setting for resolution of acute symptomatology. Medication can be titrated. Symptom reduction is part of recovery

Community integration-Everything from discharge planning to going into the community with the person who receives the care is important. Community staff can have access to hospital treatment team meetings.

Quality of Life-A reasonable quality of life is to be insured. This can take place in a hospital setting.

VALUE OF PSYCHIATRIC REHABILITATION

-Self determination-Giving each person input on their goals and interventions is an example of what can be done with in the the hospital to promote self determination. -Planning together and Participating can be part of the self determination process.
-Hospitals Overcrowding-These locations have little chance of people being treated with dignity.
-Promoting Optimism and Hopefulness-This is needed but not always emphasized in hospital settings.
-Capacity of every individual to learn and grow-These values should be demonstrated by skills training activities, career exploration and opportunities to explore hobbies and interests.
-Cultural sensitivity-Not the sensitivity of the dominant staff culture. Staff can attend to the cultural interests and backgrounds of the people who they serve.

GUIDING PRINCIPLES OF PSYCHIATRIC REHABILITATION
-Individualization-Hospitals are geared toward serving people in mass. Having a Recovery Mall or Peer Support or Drop In Centers or Individual skills classes can help.
-Maximum client involvement, choice, preferences and choice-Participation in treatment planning, choosing of activities, and contributing to what are discharge preferences can help implement these principles.
-Normalized community service-provide housing which is more community housing by beginning participation in cottages which are more like community living.
-Strengths focus-Some hospitals focus on weaknesses and deficits. The attention can be focused on different services that can potentially engage and interest these individuals by having a variety of services available.

-Situational assessments-Hospitals have not done well at this. Sometimes the hospital can have negative effects on the person's coping skills. The person needs to be seen in real life situations to understand what is their potential
-Holistic approach-Sometimes the hospital focuses on the symptom management. There are many resources available to have for the person which can help in their lives.
-Ongoing, accessible coordinated services-This could be in hospitals but there are overlapping of reporting lines among staff and narrow divisions of responsibilities keep this from happening. Hospitals need to work on simplified reporting and work on team functioning. Coordinate with community providers whenever possible.
-Skills Training-Skills training takes place within the hospital but many times these skills are not tied to living in the community. Provision must be made for transfer of skills into the community.
-Environmental modifications and suppports- Hospital staff resist modifying hospital environments to accommodate individual preferences.
-Partnership with the family-When the family is involved full participation in the discharge becomes critical. Support meetings on hospital grounds and family advisory group are all necessary.
-Vocational focus-Any vocational work should focus on clarification of the person's vocational goals, employment preference and pursuit of opportunities in the person's home community.

PSYCHIATRIC REHABILITATION MODELS IN THE HOSPITAL
1. Social Independent Living Skills(SILS)
2. Psychiatric Rehabilitation Integrated Service Model(PRISM)
3. Treatment Mall

SOCIAL AND INDEPENDENT LIVING SKILLS MODEL

Staff teach specific skills and skill training relevant to social and independent living.

-Social skills
-Symptom management skills
-Medication management skills
-Community re entry skills

PSYCHIATRIC REHABILITATION INTEGRATED SERVICE MODEL

The PRISM approach
-Patient participation in treatment planning meetings
-Treatment plans with rehabilitation focus that emphasizes goals , skill development and development of external support
-Problem re conceptualization as obstacles that need to be overcome to reach independent living skills.
-True patient participation in treatment plan meetings

-Involvement of family member(with consent of patient) and community providers directly in the treatment team

Also
-Community meetings co lead by patients and staff
-The development of patient committees on each unit to advise staff leaders regarding patient concerns
-Meetings of patient representatives or advisors from each ward with hospital and administrators.

The PRISM approach requires staff training, emphasizing interaction with patients and promotion of patient choice.

TREATMENT MALL

Programs are delivered in another area off from the established hospital. The hospital is more like a dormitory. The Mall offers opportunities both vocational and recreational. The Mall offers consumer choice by offering an array of activity options.

IMPLEMENTING PSYCHIATRIC REHABILITATION EASTERN STATE HOSPITAL

Recognizing the obstacles for implementing psychiatric rehabilitation was essential
-Most staff members believed that television watching and naps were acceptable for most patients most of the time.
-Team members often expressed the belief that acutely ill patients were generally unable to participate in activities.
-Staff members view psychosocial treatment as being solely in the realm of occupational, recreational and activity therapists, not doctors, nurses and social workers.

Like most hospitals

Eastern state also had
-History of emphasizing biological treatment, primarily medication
-An emphasis on maintaining a safe environment for staff and patients
-Lack of treatment team ownership of responsibility of individual patients
-Numerous patients with chemical or substance abuse dependency
-Programs that are not always individualized to the patient's unique needs

How was Psychiatric Rehabilitation implemented?

Peer coaches were assigned to each team to encourage interdisciplinary approach that included an emphasis on psychiatric rehabilitation.

What needed to be done was:
-Clarify each person's goals, promoting their freedom of choice, enhancing their privacy and dignity and increasing their time with family and friends when they were still in the hospital setting.
-Educate each person about the nature of his or her illness and how medications work to restore self confidence(Illness Management)
-Teach about medication and its side effects, self monitoring, and communicating with the psychiatrist and other members of the treatment team.
-Connect with the family other members of natural support in the community.
Enable the person to make appropriate aftercare plans for residential and continuing treatment after discharge.

IS HOSPITALIZATION ALWAYS NECESSARY?

This is a debate there are several are several alternatives out there which are more in harmony with the principles of psychiatric rehabilitation.

ADDRESSING ACUTE CARE NEEDS WITHOUT LARGE HOSPITALS

-Acute partial hospitalization There is a large body of literature that partial hospitals are better than inpatient. Programming is available 6 to 12 hours a day with maximum length of stay 4 to 8 weeks

-Crisis residential care These units provide care 24 hours a day and seven days a week. They have a very small census. They look more like a group home than a hospital.
-Early intervention teams Comprehensive teams intervene at the first signs of psychosis and continue to follow the person as long as needed.

-In home crisis intervention and psychosis management A number of strategies are used to manage psychotic disorders in the home through crisis intervention approaches. Personal assistants and intensive familial supports where appropriate.

Combinations of one or more of these interventions

INTERMEDIATE AND LONG TERM CARE NEEDS WITHOUT LARGE INSTITUTIONS.

There are residences in the community with staff twenty four hours a day and seven days a week. There should be a great deal of extra places for people in the community.,

The reason for more places in the community for people is that in the hospital two or three or more people fill a spot every year. In the community that spot is filled by one person.

SUMMARY

Public Psychiatric hospitals remain a part of the mental health system in many places. The research shows that people who are deinstitutionalized with proper supports have better outcomes.

Having people go to the community has problems because many community providers may be reluctant to serve those who are very ill.

Hospitals can learn to provide instruction on how to better integrate into the community.

Hospital stays that are there for a couple of weeks are conducive to recovery.
Long stays can work against recovery by encouraging passivity.

Treatment programming in a hospital should be offered according to the principles of psychiatric rehabilitation and based on evidence based practice.

Also, during the course of a hospital stay and effort should be made to coordinate hospital and community staff for eventual return to the community of people.